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IN THE
Supreme Court of the United States
OCTOBER TERM, 1993

THE METHODIST HOSPITAL, *et al.*,
Petitioners,

v.

DONNA E. SHALALA, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Respondent.

Petition for a Writ of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

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APPENDIX TO PETITION FOR A WRIT OF CERTIORARI

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 91-5401

THE METHODIST HOSPITAL, *et al.*

v.

DONNA E. SHALALA, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES

and Consolidated Cases 91-5436, 92-5210 & 92-5248

Before: BUCKLEY, GINSBURG, and HENDERSON, *Circuit Judges.*

JUDGMENT

[Filed Sep. 16, 1993]

This appeal was considered on the record from the United States District Court for the District of Columbia and on the briefs of counsel. The court is satisfied, after reviewing the parites' briefs, that appropriate disposition of the case does not call for further opinion. *See* D.C. Cir. R. 14(c).

We reverse the district court's summary judgment that the adjustments provided for under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) at 42 U.S.C. § 1395ww(b)(4)(A) are incorporated into § 1395ww (d) for hospitals subject to the Medicare Program's Prospective Payment System (PPS) during the four-year transition period from the TEFRA-mandated system to

PPS. *Episcopal Hospital, et al. v. Shalala,* 994 F.2d 879 (D.C. Cir. 1993) holds squarely to the contrary. Methodist Hospial's second argument in this appeal, that an award of interest should accompany any payment made to the hospitals as a result of the present litigation, is therefore moot.

ORDERED and ADJUDGED that the summary judgment from which this appeal has been taken be reversed.

The clerk is directed to withhold issuance of the mandate herein until seven days after disposition of any timely petition for rehearing. *See* D.C. Cir. R. 15(b)(2).

Per Curiam
FOR THE COURT:

/s/ Ron Garvin
RON GARVIN
Clerk

APPENDIX B

UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

Argued March 18, 1993 Decided June 18, 1993

Nos. 92-5033 & 92-5034

EPISCOPAL HOSPITAL, *et al.*,
Appellants

v.

DONNA E. SHALALA, SECRETARY,
HEALTH AND HUMAN SERVICES

Appeals from the United States District Court
for the District of Columbia
89cv01716 & 91cv01657

Mark H. Gallant argued the cause for appellants.

Linda A. Ruiz, Attorney, Department of Health and Human Services, argued the cause for appellee. With her on the briefs were *Stuart M. Gerson,* Assistant Attorney General, *Jay B. Stevens,* United States Attorney at the time the brief was filed, and *John D. Bates,* Assistant United States Attorney. *R. Craig Lawrence,* Assistant United States Attorney, also entered an appearance for appellee.

Before EDWARDS, SENTELLE, and HENDERSON, *Circuit Judges.*

Opinion for the Court filed by *Circuit Judge* SENTELLE.

SENTELLE, *Circuit Judge*: This is an appeal from a District Court judgment upholding the validity of regulations issued by the Secretary of Health and Human Services (the "Secretary") under 42 U.S.C. § 1395ww(d) (1988), which sets forth the methodology for calculating hospitals' Medicare cost reimbursement under the Prospective Payment System ("PPS"). Appellants argue that the Secretary's PPS regulations are based in part on an erroneous interpretation of the enabling statute, or are arbitrary and capricious. The District Court disagreed; we reach the same result and therefore affirm the District Court's judgment.

I. BACKGROUND

A. *Statutory and Regulatory Framework*

Part A of the Medicare Program, 42 U.S.C. § 1395c *et seq.* (1988 & 1991 Supp. III), authorizes payment for primary institutional care, such as hospital services, to eligible aged and disabled persons. Providers of these services are reimbursed by fiscal intermediaries designated by the provider and the Secretary. 42 U.S.C. § 1395h (1988); 42 C.F.R. § 421.103 (1992). Under Part A, Medicare beneficiaries receive coverage for 90 days of hospital inpatient services in each benefit period, as defined by the statute and regulations, plus an additional 60-day lifetime reserve. 42 U.S.C. § 1395d (1991 Supp. III); 42 U.S.C. § 1395q (1988); 42 C.F.R. § 409.60 *et seq.* (1992).

Until October of 1983, the Medicare Program reimbursed hospitals and other health care providers for the "reasonable cost" of covered services, defined as the "cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x(v) (1988). Under this reasonable-cost regime, hospitals providing inpatient care to Medicare patients received reimbursement for allowable operating costs of services

provided to patients, but only to the extent the services were provided on days for which the patients had Medicare coverage. *Id.* § 1395q(d).

Concerned that hospitals had little incentive to reduce or contain costs because reasonable cost reimbursement shifts the burden of cost increases from hospitals to the federal government, Congress enacted provisions in the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), Pub. L. No. 97-248, 96 Stat. 324 (1982) (codified at scattered sections of 42 U.S.C.), to address containment of Medicare costs. While the TEFRA provisions left the basic retrospective, cost-based structure of Part A reimbursement undisturbed, it imposed a limit on the rate of increase of Part A reimbursement.

Under TEFRA, the rate-of-increase limit for each hospital was tied to a "target amount." This amount was the hospital's allowable costs of inpatient hospital services for the preceding cost reporting period, increased by a specified percentage in each succeeding cost reporting preiod. 42 U.S.C. § 1395ww(b)(3)(A) (1988). Though hospitals were subject to reductions in the amount of their Part A reimbursements if their operating costs exceeded the applicable target amounts, *id.* § 1395ww(b)(1)(B), they received bonuses if their operating costs were less than their target amounts. *Id.* § 1395ww(b)(1)(A); 42 C.F.R. § 413.40 (1992).

TEFRA also set out specific exceptions and adjustments to the new limits. Section 1395ww(b)(4)(A) directed the Secretary to "provide for an exemption from, or an exception and adjustment to, the [rate of increase] method . . . where events beyond the hospital's control or extraordinary circumstances . . . create a distortion in the increase in costs for a cost reporting period." 42 U.S.C. § 1395ww (b)(4)(A). In addition, the subsection authorized the Secretary to "provide for such other exemptions from, and exceptions and adjustments to, such method as the Secre-

tary deems appropriate." *Id.; see also* 42 C.F.R. § 413.40 (f)-(g) (exemptions and adjustments).

In 1983, Congress replaced the TEFRA-mandated system with a more radical reform of inpatient cost reimbursement, known as the Prospective Payment System. *See* Pub. L. No. 99-272 § 9102, 100 Stat. 155 (1986) (codified as amended, 42 U.S.C. § 1395ww(d) (1988 & 1991 Supp. III)); 42 C.F.R. § 421.1 *et seq.* (1992). Under this system, hospitals and other health care providers are reimbursed on the basis of prospectively determined national and regional rates, rather than reasonable operating costs. The system classifies Medicare patients into one of approximately 470 "diagnosis related groups" ("DRGs") based on differences in patients' utilization of hospital resources by groups and establishes fixed rates for each. The PPS rates do not vary according to the actual costs of individual cases, but are designed to allow efficient providers to recover their average costs of serving Medicare patients during a cost reporting period.

In enacting the PPS, Congress simultaneously provided for various exceptions and adjustments, as it had when it enacted TEFRA's rate-of-increase limit. Section 1395ww (d)(5) directs the Secretary to implement specific exceptions and adjustments, 42 U.S.C. § 1395ww(d)(5)(A)-(H), and to provide by regulation for other exceptions and adjustments to payment amounts "as the Secretary deems appropriate." *Id.* § 1395ww(d)(5)(I). In contrast to the analogous provision in TEFRA, however, § 1395ww(d) (5)(I) does not direct the Secretary to adjust reimbursement amounts where "extraordinary circumstances" distort the increase in costs for a particular cost reporting period.

Though eager to restrain health care costs, Congress recognized that immediate institution of the PPS could pose financial hardship for many health care providers. It therefore created a four-year transition period between the reasonable cost system and the PPS, 42 U.S.C. § 1395

ww(d), designed to "minimize disruptions that might otherwise occur because of sudden change in reimbursement policy." H.R. REP. No. 25, 136, 98th Cong., 1st Sess., *reprinted in* 1983 U.S.C.C.A.N. 355.

During the transition period, the government was required to reimburse hospitals for inpatient hospital services according to a "blended" rate, based upon two components. The first was the hospital-specific portion ("HSP"), defined as a hospital's "allowable operating costs of inpatient hospital services" in a prior base year, *i.e.*, the Medicare cost year ending on or after September 30, 1982. 42 U.S.C. § 1395ww(b)(3)(A). The HSP is a percentage of the hospital's target amount as defined in subsection (b)(3)(A). The second element was the "federal" portion, a computation from regional and national DRG rates approaching the PPS rate. 42 U.S.C. § 1395 ww(d)(2)(A), (B). Over the course of the four-year transition period, the portion of the reimbursement amount attributable to the prospective rate became progressively larger and HSP progressively smaller, until the prospective rate formed the exclusive basis for PPS reimbursement at the end of the transition period. *Id.* § 1395ww (d)(1)(C).

In implementing the PPS, the Secretary promulgated regulations modifying prior Medicare coverage rules. *See* 48 Fed. Reg. 39,752 (1984) (codified at 42 C.F.R. § 405 *et seq.* (1992)). Inpatient hospital stays involving at least one day of Medicare eligibility would be treated as fully "covered" stays under Part A, for which the PPS payment itself would represent payment in full regardless of the length of stay or extra costs attending the patient's recovery. 42 C.F.R. § 412.2(b)(2) (1992) (formerly 42 C.F.R. § 405.70(b)(2)(ii) (1984)). Because hospitals were prohibited from billing costs not fully reimbursed by Medicare, *id.* § 412.42(a), the "balance," in effect, was no longer reimbursable.

B. *Facts*

Appellants in this case are seven short-term acute care hospitals providing inpatient care under the Medicare program. Through their fiscal year ending June 30, 1984, appellants received reimbursement under the reasonable cost system. During the transition years, their PPS rates, including the HSP, were calculated by their intermediaries before the start of their first year under the PPS and were annually updated and used to determine their PPS payments per discharge. Excluded from the base-year costs were costs associated with care furnished to Medicare beneficiaries for hospitalization after their Medicare coverage had been exhausted, costs for which Medicare had reimbursed the hospitals under the reasonable cost system. The hospitals sought an adjustment from their intermediaries to include these costs in the base-year totals, for purposes of calculating the HSP of their PPS rates. The intermediaries declined to adjust the costs because the Secretary's regulations did not provide for such an adjustment. The hospitals appealed to the Provider Reimbursement Review Board, which, on April 12, 1989, certified the issue for expedited judicial review pursuant to 42 U.S.C. § 1395oo(f) (1988).

The hospitals then filed the present action in the United States District Court on June 15, 1989, requesting an order compelling the Secretary to compensate them for costs that were improperly excluded from the hospital-specific portions of their transition-year payment rates. On cross-motions for summary judgment, the District Court reviewed the record and concluded that the Secretary had acted lawfully in not providing for adjustments to hospitals' base-year costs to reflect costs associated with care furnished to patients after their Medicare coverage had been exhausted. *Episcopal Hosp. v. Sullivan*, Medicare & Medicaid Guide, (CCH) ¶ 39,817 (D.D.C. 1991). The court assumed, without discussion, that 42 U.S.C. § 1395ww(b)(4)(A), which authorizes the Secretary to make adjustments in "extraordinary circumstances," applies to transition rates

under PPS. However, the court upheld as based on a permissible reading of the statute the Secretary's conclusion that promulgation of a new regulation treating exhausted stays differently than under reasonable cost reimbursement was not an event "beyond the hospital's control or extraordinary circumstances" within the meaning of § 1395 ww(b)(4)(A). The court also concluded that the Secretary did not abuse her discretion under § 1395ww(d)(5)(D) to provide the adjustment the hospitals sought.

This appeal followed.

II. Discussion

Appellants argue in the first instance that the plain meaning of the enabling statute required the Secretary to make adjustments they seek. In the alternative, they argue that even if the statute does not require the Secretary to make the requested adjustments, the Secretary's refusal to make the base-year adjustments was arbitrary and capricious.

Chevron, U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984), provides the proper framework for the statutory interpretation issue. That case held that

> First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. . . . [However,] if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.

Id. at 842-43.

Appellants rely on § 1395ww(b)(4)(A), which states that "[t]he Secretary shall provide for an exemption from,

or an exemption and adjustment to, the [statutory rate of increase] method . . . where events beyond the hospital's control or extraordinary circumstances . . . create a distortion in the increase in costs for a cost reporting period." 42 U.S.C. § 1395ww(b)(4)(A). They note that § 1395 ww(d)(1)(A)(i)(I) incorporates by reference the TEFRA "target rate" definition of subsection (b)(3), for purposes of setting the PPS base-period, hospital-specific costs. Subsection 1395ww(b)(3), they argue, is in turn subject to the provisions of subsection 1395ww(b)(4) (A), which requires the Secretary to make adjustments to the target rate in "extraordinary circumstances." *Id.* § 1395ww(b)(4)(A). Thus, appellants conclude that § 1395ww(d)(1) explicitly incorporates subsection (4) (A)'s extraordinary-circumstances mandate.

We do not agree. Section 1395ww(b)(3)(A), defining "target amount," plainly does *not* incorporate subsection (b)(4)(A). In fact, section 1395ww(b)(3)(A) never mentions that subsection, although it does refer to other exceptions from the target amount method determined under subparagraph (b)(3)(A). *See* 42 U.S.C. § 1395ww (b)(3)(A). Nor does subsection (b)(4)(A) either define "target amount" or modfiy the definition set forth in (b)(3)(A). In fact, subsection (b)(4)(A) explicitly authorizes the Secretary to depart from the "target amount" benchmark in (b)(3)(A) in specific circumstances, suggesting that incorporation of (b)(4)(A) might conflict with the congressional intent partially to base reimbursement on the target amount during the PPS transition period. Certainly, the fact that Congress clearly incorporated subsection (b)(3)(A), while never referring to subsection (b)(4)(A), suggests that when Congress intended to incorporate a TEFRA provision into PPS, it did so expressly and that it did not intend to incorporate the provision at issue here.

Furthermore, appellants are unable to reconcile their argument with § 1395ww(d)(5). That section mandates

specific adjustments and exceptions to the amount a hospital may be reimbursed for its inpatient operating costs under the PPS, *see* § 1395ww(d)(5)(A)-(H), and gives the Secretary general authority to provide for other exceptions and adjustments "as the Secretary deems appropriate." *Id.* § 1395ww(d)(5)(I). The quoted language also appears in subsection (b)(4)(A); significantly, however, subsection (d)(5) contrasts with subsection (b)(4)(A), insofar as the former does not include a provision for upward modification of a hospital's target rate in "extraordinary circumstances." *Compare* 42 U.S.C. § 1395ww(d)(5)(I) *with id.* § 1395ww(b)(4)(A).

In light of the foregoing, not only are we unable to agree with appellants that the statute requires the Secretary to make the requested adjustments, but it appears that the meaning may be quite the contrary. Even if we admit the possibility of other interpretations, appellants still do not prevail. Under the second step of *Chevron*, we "need not conclude that the agency construction was the only one it permissibly could have adopted to uphold the construction, or even the reading the court would have reached if the question initially had arisen in a judicial proceeding." *Chevron*, 467 U.S. at 843 n.11. We need only determine "whether the agency's answer is based on a permissible construction of the statute." *Id.* at 843. In short, to the extent that the statute is ambiguous, the Secretary's interpretation, which is a permissible one for the reasons given above, must be upheld.

Having upheld the Secretary's reading of the statute under the *Chevron* analysis, we turn to appellants' second argument, that the Secretary's promulgation and application of the implementing regulations was arbitrary and capricious.

The appropriate standard for reviewing the Secretary's exercise of the discretion afforded under the statute is dictated by 42 U.S.C. § 1395oo(f)(1), which incorporates the Administrative Procedure Act ("APA"), 5 U.S.C.

§ 706(2)(A) (1988). Under the APA, we hold unlawful and set aside only those agency actions that we find "arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law." *Id.* Insofar as the question of whether the Secretary's regulations are in accordance with law, it follows from our analysis above the Secretary acted consistently with the statutory mandate, and in furtherance of the congressional goals.

As to the argued arbitrariness or capriciousness of the form she chose for doing so, we have often made it plain that we do not sit to interfere with the policy decisions of an agency, *Ethyl Corp. v. EPA*, 541 F.2d 1, 34 (D.C. Cir.) (en banc), *cert. denied*, 426 U.S. 941 (1976) (noting that this Court is "forbidden from substituting [our] judgment for that of the agency"), and we will not do so here. A review of the Secretary's official explanation of the final rules, 49 Fed. Reg. 234, 246-49 (1984), reveals that the Secretary responded to the comments that were in fact submitted. She revealed her goals and reasoning. She gave us a record which "will enable us to see what major issues of policy were ventilated by the . . . proceedings and why the agency reacted to them as it did." *Walter O. Boswell Mem. Hosp. v. Heckler*, 749 F.2d 788, 794 (D.C. Cir. 1984) (internal quotation marks omitted). She did, in short, all that the APA required.

We note that the root cause of appellants' objection to the PPS implementing regulations lies not in the refusal of adjustments, but rather in 42 C.F.R. § 412.42 (a), which prohibits hospitals from charging Medicare patients whose bills exceed the amount paid to the hospital under the PPS. That regulation reads as follows:

> A hospital may not charge a beneficiary for any services for which payment is made by Medicare, even if the hospital's cost of furnishing services to that beneficiary are greater than the amount the hospital is paid under the prospective payment systems.

Id. Obviously, this regulation may prevent health care providers from recouping losses which they may sustain when a Medicare patient remains with them beyond the average stay per ailment or requires greater than average care. There is, however, nothing we can do for appellants in this regard as they have not challenged § 412.42 (a), but only the Secretary's discretionary refusal to adjust the base-year computations to offset the effect of the change in regulations. *See Association of Accredited Cosmetology Schools v. Alexander,* 979 F.2d 859, 862 (D.C. Cir. 1992) (courts ordinarily do not address new legal theories on appeal).

III. Conculsion

For the reasons set forth above, we hold that the plain language of the PPS statute and its implementing regulations support the Secretary's contention that the PPS does not include an "emergency circumstances" provision. Further, the Secretary's implementation of the statute was neither arbitrary, capricious, nor unlawful. Therefore, the judgment of the District Court is hereby

Affirmed.

APPENDIX C

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

Civil Action No. 90-1871

THE METHODIST HOSPITAL and ST. VINCENT'S HOSPITAL AND MEDICAL CENTER OF NEW YORK,
Plaintiffs,

v.

LOUIS W. SULLIVAN, M.D.,
Defendant.

MEMORANDUM AND ORDER

[Filed Oct. 22, 1991]

The Court filed an order disposing of the parties' cross-motions for summary judgment on September 20, 1991. On October 2, 1991, defendant filed a motion to alter or amend the judgment in regard to the issue of who bears the burden of proof on remand, and on October 4, plaintiffs filed a motion to amend the judgment to impose a time limit on the Secretary's action on remand.

I

Defendant argues in his motion that the Court has impermissibly shifted the burden of proof to the Secretary in the hearing to be conducted pursuant to the remand order. The Secretary, however, has misinterpreted the Court's order. In its September 20, 1991 Memorandum, the Court held that the TEFRA adjustments of 42 U.S.C. § 1395ww(b)(4)(A) apply to the PPS provisions of 42 U.S.C. § 1395ww(d)(1)(A), and that the Secre-

tary must on remand consider whether the expenses claimed by plaintiffs fall within the "extraordinary expenses" clause of (b)(4)(A). The Court did not shift the burden of proof in any way from what it normally would be in a PRRB or other Department hearing. The burden mentioned in the Court's Order referred to the burden that the Court was imposing on the Secretary and his intermediary, as a condition of remand, to provide plaintiff a full opportunity to present proof, and to issue "a detailed explanation of the grounds on which such request was approved or disapproved." 42 U.S.C. § 1395 ww(b)(4)(A). As the Court indicated, the Secretary's duty under this statutory provision must in this case be construed as including the burden of complying with the Court's holding as expressed in the Memorandum of September 20.

The defendant's motion to alter or amend the judgment is thus denied.

II

In their motion to amend the judgment, plaintiffs request that the Court impose a limit of 90 days within which defendant's intermediary must make a determination as to plaintiffs' requested adjustment. The Court declines to impose such a limitation. The amount of discovery that will be necessary to comply with the remand cannot be determined at this point by either party, and such a limitation would therefore be imprudent. The Court does expect, however, that the Secretary will act expeditiously to comply with the remand, and any undue delay may be brought to the Court's attention.

Plaintiffs' motion to amend the judgment is thus denied.

SO ORDERED.

/s/ Gerhard A. Gesell
United States District Judge

October 22, 1991.

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 90-1871

THE METHODIST HOSPITAL and ST. VINCENT'S HOSPITAL AND MEDICAL CENTER OF NEW YORK,
Plaintiffs,

v.

LOUIS W. SULLIVAN, M.D.,
Defendant.

MEMORANDUM

[Filed Sep. 20, 1991]

Plaintiffs, two New York hospitals, appeal a final determination of the Provider Reimbursement Review Board ("PRRB") of the Department of Health and Human Services, which the Health Care Financing Administration ("HCFA") declined to review. No further agency appeals remain. Because the cases relate to the same questions, they were consolidated at the agency level and have been appealed together. The issues are before the Court on cross-motions for summary judgment that have been fully briefed and argued. There are no genuine issues of material fact.

I

In April 1983, Congress radically changed the way that Medicare was to pay hospitals that provided inpatient care to patients covered by Medicare. Up until that time, Medicare reimbursed hospitals for the "reasonable cost" of the care they actually provided to Medicare

patients; the method of calculating a hospital's reasonable costs and the limits on charges and increases had been amended most recently by the Tax and Fiscal Responsibility Act of 1982 ("TEFRA"). In contrast, a subsequent statute, the Social Security Amendments of 1983, Pub. L. No. 98-21, title VI, provided for prospectively determined fixed-rate payments to hospitals based on patients' diagnosis-related groups ("DRG"). The goal of the new prospective payment system ("PPS") was to provide hospitals more of an incentive to find ways of keeping their costs down. *See* H.R. Rep. No. 98-25, 98th Cong., 1st Sess. 132, *reprinted in* 1983 U.S. Code Cong. & Admin. News 143, 219, 351. The reasoning was that if the hospital knew the amount of money it was to receive for a particular diagnosis and treatment, it would strive to keep its costs below that amount.

To smooth the transition from the old system to the new one, the statute provided for a four-year phase-in period, during which time Medicare reimbursement to hospitals was to be computed partly on the basis of the older method as modified by TEFRA and partly on the basis of the new prospective payment system. The issue in the case currently before the Court relates to the method of calculating the amount of money due each of the hospitals during this PPS transition period.

Under TEFRA, a hospital's reimbursement is determined with reference to a statutory "target amount." Essentially, the target amount, as defined at 42 U.S.C. § 1395ww(b)(3), is based on the hospital's allowable operating costs during a particular twelve-month reportig period ("the base year"). To calculate the reimbursable amount for a year subsequent to the base year, the target amount is increased by an amount estimated by the Secretary according to "an index of appropriately weighted indicators of changes in wages and prices. . . ." 42 U.S.C. § 1395ww(b)(3)(B).

Congress recognized, however, that simply taking the isolated base year as the starting point for calculating the reimbursable amount in later years might sometimes not accurately reflect a hospital's true costs in those later years. A change "in the case mix of such hospital," for example, might make a strict application of the target amount method inequitable. 42 U.S.C. § 1395ww(b)(4)(A). In addition to the simple base-year-plus calculation described above, therefore, TEFRA directs the Secretary to "provide an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances . . . create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured)." 42 U.S.C. § 1395ww(b)(4)(A).

As stated above, the shift from the TEFRA method just described to PPS was to be accomplished gradually, by calculating Medicare reimbursement for several years partly on the basis of TEFRA and partly on the basis of PPS. Instead of rewriting the TEFRA rules in the statutory section setting out the phase-in calculations, however, Congress simply cross-referenced the TEFRA section of the statute. Specifically, the PPS statute stated that the TEFRA component of the phase-in period reimbursement should be determined "as defined in subsection (b)(3)(A) of this section. . . ." 42 U.S.C. § 1395ww(d)(1)(A)(ii)(I). And therein lies the problem of statutory interpretation that is so hotly contested in this case. Section (b)(3)(A) describes only the base-year-plus part of the TEFRA callculations. It does not contain the TEFRA provisions relating to increases because of "extraordinary circumstances." Those latter provisions are contained in (b)(4)(A), which elaborates and modifies (b)(3)(A). The heart of the issue, then, is whether the PPS phase-in provisions incorporate (b)(4)(A) as well.

II

For purposes of calculating the plaintiff hospitals' TEFRA portion of the phase-in reimbursements, 1982 is the base year. Thus, the costs experienced in 1982 were used to determine the amounts due the hospitals from Medicare during the relevant portions of the phase-in period. In 1983, however, the hospitals began to experience increases in their operating costs as the result of major construction that had begun earlier. The hospitals' claim is that these increased operating costs associated with the construction are extraordinary expenses that should have been taken into account pursuant to (b)(4)(A) in calculating the TEFRA portion of the phase-in reimbursement.

As support for their position, plaintiffs point out that those costs were taken into account during the so-called "New York waiver." The New York waiver refers to a portion of the PPS statute that allowed certain states to be exempt from the Medicare payment system for several years during the phase-in period, in order to allow those states to implement experimental payment programs. *See* 42 U.S.C. § 1395ww(c). Under the New York waiver, the New York State Commissioner of Health, rather than the federal authorities, approved hospital reimbursement rates for inpatient care covered by Medicare. Thus, from January 1, 1983, until December 31, 1985, plaintiff hospitals were subject to a separate payment plan, and reimbursement for those years is therefore not at issue in the current action. It is only the reimbursement rate for the time following the New York waiver until the end of the PPS phase-in period that is at issue here, namely January 1, 1986 through February 21, 1988. Plaintiffs argue that for the years of the New York waiver, the state Commissioner—who plaintiffs say was essentially the Secretary's "alter ego"—allowed the increased operating costs as reasonable, and that the Secretary should have done so as well during the remainder of the phase-in period. Plain-

tiffs assert that the plain meaning of the statute indicates that (b)(4)(A) should be construed as modifying (b)(3)(A) even for purposes of the phase-in calculations, and that the legislative history and applicable judicial precedents support this position.

III

According to 42 U.S.C. § 1395oo(f)(1), the proper standard of judicial review of the agency's actions in this case can be found in the Administrative Procedure Act. In particular, the court must set aside the agency decision if it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706. On the other hand, if "the intent of Congress is clear, that is the end of the matter." *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842 (1984).

Defendants argue that the intent of Congress *was* clear. They point out that the PPS phase-in provision refers to (b)(3)(A), only to (b)(3)(A), and not to (b)(4)(A). As a result, they contend, Congress could not have meant to include (b)(4)(A); otherwise, Congress would have referenced (b)(4)(A) just as it referenced (b)(3)(A).

In interpreting these same statutory provisions, however, the D.C. Circuit has instructed that the "inquiry into congressional intent must encompass both the particular language, as well as the broader design of the statute." *Georgetown University Hospital v. Bowen*, 862 F.2d 323, 326 (D.C. Cir. 1988). And indeed, the structure, specific wording, and legislative history of the statute suggest that Congress did mean to include (b)(4)(A) in the phase-in period calculations. The whole point of the phase-in provisions is to implement PPS gradually, by blending the old and new payment systems; and the old system included (b)(4)(A). As Judge Louis Oberdorfer noted in considering almost the exact same issue, "[s]ubsection (b)(4)(A) establishes exceptions to subsection (b), including

(b)(3)(A). For this reason, subsection (b)(3)(A) cannot be cleanly extracted from its statutory environment, even if Congress neglected to refer to (b)(4)(A) explicitly." *Newport Hospital and Clinic, Inc. v. Louis W. Sullivan*, slip op. at 14-15 (D.D.C. September 24, 1990). That holding reflects adherence to the D.C. Circuit's decision in *Georgetown University Hospital v. Bowen*, which indicated in a situation analogous to the one in the present case what the implications of the Secretary's argument would be if they were adopted:

> The Secretary's approach . . . has the effect of paring back hospital payments even further than was envisioned by the terms of PPS. It is implausible for the Secretary to suggest that Congress intended these results to flow from its phase-in scheme; by all outward appearances, the transition period was designed to soften the blow dealt by the new system to hospitals, but, according to the Secretary's interpretation, this period would effectively become a Trojan horse inside which a further cost-cutting measure was hidden.

862 F.2d at 329. The D.C. Circuit in *Georgetown* went on to conclude that the extra, hidden, cost-cutting result inherent in the Secretary's interpretation was clearly not intended by the legislators. *See* 862 F.2d at 330.

The Secretary's attempt to ground his position on a close reading of the words of the statute is unpersuasive. The reference to TEFRA within the PPS phase-in provisions is worded as follows: "as defined in subsection (b)(3)(A) of this section, but determined without the application of subsection (a) of this section." 42 U.S.C. § 1395 ww(d)(1)(A)(ii)(I). Defendant claims that by referring only to (b)(3)(A), Congress was intentionally excluding everything else, including (b)(4)(A). But if that reading of Congress's intent is accurate, there would have been no reason to specifically exclude "subsection (a)," as the statute does. Subsection (a) would have been excluded,

like subsection (b)(4)(A), along with everything else not specifically included. Clearly, defendant has misread Congress's obvious assumption that a statutory gloss on the section mentioned did not itself have to be referenced explicitly.[1]

IV

Having resolved the question of (b)(4)(A)'s applicability during the PPS phase-in period, the Court must still address the issue of whether the hospitals' asserted expenses qualify under that section. Plaintiffs argue that the increased operating costs associated with their capital improvements are precisely the type of extraordinary expenses that would have merited an increased reimbursement under TEFRA and its implementing regulations. *See* 42 C.F.R. § 413.40 (1989). Consequently, plaintiffs argue, they ought to receive an adjustment under the PPS phase-in as well. Part of what might be preventing such an adjustment, aside from the statutory question discussed above, is that the regulations for PPS are phrased differently from the regulations for TEFRA. *See* 42 C.F.R. § 412.71, 412.72 (1989). In particular, the PPS regulations provide for downward adjustments to the base year, but not upward adjustments.

The Court need not speculate as to why the regulations under the two statutes are different, or as to whether the difference might be attributable to the Secretary's misconstruction of the statute, as detailed above. Nonethe-

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[1] This conclusion seems buttressed by the legislative history. As the Conference Report states: "The managers recognize that, in some cases, the Secretary will have to use estimates to adjust some portions of the hospital's base year experience to make it comparable to inpatient operating costs that will be paid under the prospective system . . . ." H.R. Conf. Rep. No. 47, 98th Cong., 1st Sess. 182, *reprinted in* 1983 U.S. Code Cong. & Admin. News 404, 472. Though the passage seems to be, at best, equivocal support for either position, the Court reads it as indicating Congress's intent not to lock hospitals into a distorted base year figure for all the years that the base year is used in calculating reimbursement.

less, it appears to the Court that because the PPS phase-in specifically incorporates the TEFRA provisions, the regulations implementing the TEFRA provisions ought to be the same—or at least produce the same results—regardless of whether the TEFRA provisions are standing alone or are incorporated as part of the PPS phase-in. Any other result would be anomalous.

Nevertheless, the Court declines to rule on the question of whether the hospitals' expenses are extraordinary for purposes of the statute. The issue was not sufficiently considered at the agency level, *see* Def. Memo. at 43; nor, therefore, is the record before the Court adequate to support a conclusive finding one way or the other. Still, based on the information that the Court does have, the adjustments claimed by plaintiffs do appear to qualify for recognition under (b)(4)(A) at least to some extent. The regulations under TEFRA indicate, for example, that the base year should be adjusted "to take into account factors that could result in a significant distortion in the operating costs of inpatient hospital services." 42 C.F.R. § 413.40 (1989). The increased operating costs incurred by plaintiffs in conjunction with their one-time, massive capital expenditures appear to fit within that description. As a result, when this case is considered on remand, if the intermediary again determines that plaintiffs are not entitled to an adjustment, the intermediary shall have the burden, during an adversary hearing before the PRRB at which plaintiffs are present and fully participating, of showing why the adjustment is not to be made. Plaintiffs shall also be given an opportunity to present evidence to the intermediary, and to the PRRB if necessary, as to the amount of adjustment that should be made.

An appropriate Order accompanies this Memorandum.

/s/ Gerhard A. Gesell
United States District Judge

September 20, 1991.

APPENDIX E

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 90-1871

THE METHODIST HOSPITAL and ST. VINCENT'S HOSPITAL AND MEDICAL CENTER OF NEW YORK,
Plaintiffs,

v.

LOUIS W. SULLIVAN, M.D.,
Defendant.

ORDER

[Filed Sep. 20, 1991]

For the reasons stated in the accompanying Memorandum, after full briefing and oral argument on the issue, it is hereby

ORDERED that plaintiffs' motion for summary judgment is granted in part and denied in part to the extent that they oppose a remand; and it is further

ORDERED that defendant's motion for summary judgment is denied; and it is further

ORDERED that the case is remanded to the Secretary for further findings not inconsistent with the accompanying Memorandum. On remand, if the intermediary determines that plaintiffs are not entitled to the adjustment they request pursuant to 42 U.S.C. §§ 1395ww(d)(1)(A) and (b)(4)(A), the burden will be on the Secretary through his intermediary to show before the Provider Reimbursement Review Board and, if necessary, the Health

Care Financing Administration, during an adversary hearing at which plaintiffs shall fully participate, a legal basis supported by factual findings for why plaintiffs are not so entitled.

/s/ Gerhard A. Gesell
United States District Judge

September 20, 1991.

APPENDIX F

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 91-1001

GENERAL CARE CORPORATION,
Plaintiff,

v.

LOUIS W. SULLIVAN, M.D.,
Secretary of Health & Human Services,
Defendant.

ORDER

After considering the cross-motions for summary judgment, the responses thereto, and the entire record in this matter, it is hereby

ORDERED that plaintiff's motion for summary judgment is granted in part and denied in part to the extent that plainitff opposes a remand, for reasons stated in *Methodist Hospital, et al., v. Sullivan,* Civil Action No. 90-1871, Memorandum and Order (D.D.C. Sept. 20, 1991), *appeal pending,* No. 91-5401 (D.C. Cir.), and *Newport Hospital and Clinic, Inc. v. Sullivan,* Civil Action No. 88-2490, Memorandum and Order (D.D.C. Sept. 24, 1990); and it is further

ORDERED that the case is remanded to the Secretary for a prompt determination of whether or not plaintiff is entitled to the adjustment it requests pursuant to 42 U.S.C. §§ 1395ww(d)(1)(A) and (b)(4)(A); and it is further

ORDERED that defendant's motion for summary judgment is denied; and it is further

ORDERED that the Complaint is dismissed.

/s/ Gerhard A. Gesell
United States District Judge

May 1, 1992.

APPENDIX G

PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION
90-D27

Provider No. 33-0236

PROVIDER—THE METHODIST HOSPITAL
BROOKLYN, NY

VS.

INTERMEDIARY—BLUE CROSS AND BLUE SHIELD
ASSOCIATION/EMPIRE BLUE CROSS AND BLUE SHIELD

Date of Hearing—December 15, 1989

Cost Reporting Period Ended—December 31, 1986

Case No. 86-7019R

ISSUE:

Whether the Provider is entitled to an adjustment to its hospital-specific rate retroactive to the beginning of the Provider's first year under the prospective payment system?

SUMMARY OF FACTS:

The Provider is a 514-bed, not-for-profit hospital located in Brooklyn, New York. In the late 1970s, the Provider initiated a major construction and renovation program which was not completed until 1985. Although the num-

ber of licensed beds remained the same, the construction program increased the Provider's square footage by 23 percent and the number of full time equivalent employees increased from 1,735 in 1982 to 1,885 in 1985. During the period of January 1, 1983 through December 31, 1985, the Provider was reimbursed pursuant to the New York Prospective Hosptial Reimbursement Methodology (NYPHRM), which exempted New York hospitals from the general principles of Medicare reimbursement. Because of NYPHRM, the Provider did not enter into Medicare's prospective payment system (PPS) until January 1, 1986, which was two years later than most hospitals in the United States.

As a result of the major renovation and construction project, the Provider sought and obtained an increase in its reimbursement rate under the NYPHRM waiver for increased operating costs incurred after its 1982 based period and before its entry into PPS. However, since the incremental operating costs associated with the expanded facility were not incurred during the 1982 base period, the Intermediary's determination of the hospital-specific portion (HSP) of the Provider's PPS rate for fiscal year 1986 did not include these costs. During 1985, the Provider made various requests to the Intermediary for a revision to its Notice of Base Year Costs and Target Amount Calculation based upon the incremental operating costs approved under the NYPHRM waiver. On January 6, 1986, the Intermediary issued its Final Revised Notice and did not include the requested increase in operating costs for the Provider's modernization program. The Provider filed an appeal with the Provider Reimursement Review Board (Board) pursuant to 42 CFR 405.1835ff and has met the jurisdictional requirements therein. The estimated amount of Medicare reimbursement in controversy is $1,900,000.

Provider's Contentions:

The Provider contends that the Intermediary has ignored Congress' directive that the base year cost estimate must be comparable to the cost a hospital would be expected to incur during the PPS transition period. To ensure comparability, Congress expected the Intermediary to use the best data available at the time the base year estimation was made and mandated exceptions and adjustments to the base year estimate for extraordinary circumstances or other events causing significant distortions. The Provider asserts that this mandate is clearly presented in Section 1886(b)(4)(A) of the Social Security Act which states:

> The Secretary *shall provide for an exemption* from, or an *exception* and *adjustment* to, the method under this subsection for determining the amount of payment *where events beyond the hospital's control or extraordinary circumstances,* including changes in the case mix of such hospital, *create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured).* (Emphasis Added)

In keeping with congressional intent, the Health Care Financing Administration (HCFA) acknowledged its statutory obligation to make adjustments to the base year estimate as indicated by the following excerpt from the Preamble to the final PPS regulations:

> We believe the Congress intended to assure, by giving us broad authority under the law to provide for exceptions, exclusions and adjustments, that some hospitals are not advantaged or disadvantaged by unique circumstances in their base year that do not reflect their usual cost of operation per case. This intent is indicated in Section 1886(b)(4)(A) of the Act.

49 Fed. Reg. 261 (Jan. 3, 1984)

Thus, the Provider contends that, as early as January 3, 1984, HCFA acknowledged that Section 1886(b)(4)(A) was the statutory authority for PPS base year modifications as implemented through the provisions of 42 CFR 412.71 and 412.72. It is the Intermediary's failure to abide by these statutory requirements which led to the Provider's appeal in this case.

The Provider further contends that the Intermediary did not use the best data available at the time it estimated the hospital's base year cost as required by 42 CFR 412.71(d). Since Congress did not limit the "best data available" to costs or events occurring only in the base year, it is the Provider's position that the Intermediary's restrictive application of this requirement ignores reliable and uncontrovertible data which was available in 1985, the year prior to entry into PPS. Moreover, the available data revealed the unique circumstances which resulted in significant distortions between the Provider's base year estimate and the actual costs which would be incurred in the transition period. The Provider argues that this point was recognized in *Greenville Hospital System v. Bowen*, D.S.C. 1986, Civil Action No. 6:85-337-3, Sept. 16, 1986, Medicare & Medicaid Guide (CCH paragraph 35,880), wherein the court emphasized this important principle as follows:

> Congress clearly intended, and the Secretary has recognized, that the "best data available" was not to be strictly limited to data from the base year cost report but was also to include estimates needed to take into account changes between operating costs in the base year and operating costs under PPS that were known to exist at the time the rates were calculated.

The Provider asserts that when the Intermediary estimated the base year costs and determined the HSP amount in 1985, it had full knowledge of the increased operating costs which resulted from the renovation and construction project. However, rather than give consid-

eration to this reliable data available to it for the years 1982-1985, the Intermediary took a rigid and statutorily improper position of considering only costs reported in 1982. The Intermediary's action disregarded congressional intent and abrogated its statutory obligation to use the "best data available" as required under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

The Provider also contends that the Intermediary should have considered and granted an "exemption from, or an exception and adjustment" under the TEFRA adjustment provisions of Section 1886(b)(4)(A) of the Act in determining the PPS target amount. Pursuant to Section 1886(d)(1)(A)(i)(I) of Act, the amount of payment for inpatient hospital services during the PPS transition period is determined by blending the federal rate and the hospital's TEFRA target amount, as defined in Section 1886(b)(3)(A) of the Act. In accordance with Section 1886(b)(3)(A), the TEFRA target amount is calculated by multiplying the allowable operating costs of inpatient hospital services for the preceding 12-month cost reporting period by the applicable percentage increase. Since the PPS provisions of Section 1886(d)(1)(A)(i)(I) and (ii)(I) cross-refer to and incorporate by express reference the TEFRA target amount determined under section 1886(b)(3)(A), the target amount cannot be calculated without considering and, where appropriate, making the required exemption, exception or adjustment under subsection (b)(4)(A). In the absence of any express exclusion, it is the Provider's contention that the requirements of Section 1886(b)(4)(A) must be applied under established principles of statutory construction in determining the PPS target amount and resulting HSP under Section 1886(d)(1)(A).

The Provider asserts that HCFA has actually granted such TEFRA adjustments to other PPS hospitals which had requested an adjustment of base year costs after undergoing a substantial change in their facilities and/or

services prior to their entry into PPS. In each of those cases, HCFA granted a TEFRA adjustment under Section 1886(b)(4)(A) and its implementing regulation 42 CFR 413.40, and effected a PPS base year modification pursuant to 42 CFR 412.71 and 412.72, which is the same adjustment the Provider is requesting in this case. In reference to the relief granted by HCFA to Newport Hospital in Arkansas (Exhibit J-Provider's Position Paper), the Provider notes that a new facility was built after the old one failed to meet life safety code requirements. Newport Hospital opened its new facility approximately 4½ months after the start of its base year. HCFA recognized that a distortion of cost existed between the base year estimate and the costs expected to be incurred from operations at the new facility and granted a base year adjustment under 42 CFR 405.463(h) (recodified as 42 CFR 413.4(h)). A corresponding prospective adjustment was also made to Newport Hospital's HSP under 42 CFR 412.72 for PPS purposes. In addition, HCFA used actual, post-base year costs to determine the adjustment necessary to ensure that the base year estimate and PPS target amount calculation were comparable to Newport Hospital's actual costs of operations.

In a similar case involving Greenville Hospital System (GHS) in South Carolina, where two hospitals underwent a reorganization after the close of the PPS base year but prior to entry into PPS, HCFA also adjusted GHS's operating costs under 42 CFR 405.463(h) to reflect changes that had occurred to the base year costs (Provider's Exhibit M). In applying the TEFRA adjustment to these two hospitals, HCFA cited the following rationale:

> We have . . . decided to treat your request as an application for an *adjustment* to GHS's cost per case for the cost reporting period subject to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), as authorized by regulation 405.463(h)

> [*recodified* as 413.40(h)]. Under that regulation, HCFA may adjust operating costs considered in establishing a hospital's TEFRA-year cost per case to *take into account factors which could result in a significant distortion in the operating costs of inpatient hospital services.* Because of the substantial magnitude of the costs affected by the Greenville realignment, we have determined that a significant distortion in GHS's operating costs would exist without an adjustment, and *we are therefore, granting the adjustment* described below [for PPS purposes].
>
> As you know, the amount of the hospital-specific portion (HSP) of PPS payment is determined by reference to each hospital's target amount under TEFRA. (Emphasis Added)

The Provider notes that, as in the Newport Hospital case, after making the TEFRA adjustment, HCFA prospectively adjusted the estimate of base year costs and the PPS target amount pursuant to 42 CFR 412.72.

In further support of its position, the Provider also cites the case involving *Redbud Hospital District v. Heckler,* C-84-4382-MHP, (N.D. Cal., 1984). Although the provider in *Redbud* was forced to litigate to obtain an adjustment to correct the distortion in the calulation of base year costs and tarket amount, the Provider notes that HCFA did not dispute that Section 1886(b)(4)(A) of the Social Security Act authorized adjustments to the HSP calculation for PPS purposes. The Provider contends that the Intermediary has failed to advance a legally supportable argument or introduce any relevant evidence against the legal and reimbursement principles applied by HFCA in *Newport, Greenville* and *Redbud.*

The Provider also contends that the construction and renovation project which it undertook was necessary to correct substantial deficiencies which threatened the licensure and accreditation of its previous facility. Thus, it had no choice

but to renovate its old facilities or construct new ones when renovation would have been inadequate. The regulations at 42 CFR 413.40(h), which were applied by HCFA in granting the TEFRA adjustment in *Newport* and *Greenville*, state the following:

> Adjustments—(1) *Comparability of cost reporting periods* (i) *HCFA may adjust the amount of the operating costs* considered in establishing cost per case for one or more cost reporting periods, including both periods subject to the ceiling and the hospital's base period, *to take into account factors that could result in a significant distortion in the operating costs of inpatient hospital services.* The adjustments include, but are not limited to, adjustments of the base period costs to include explicitly FICA taxes (if the hospital did not incur costs for FICA taxes in its base period), and services billed under Part B of Medicare during the base period, but paid under Part A during the subject cost reporting period. (Emphasis Added)

The application of the significant distortion in operation factor, i.e., the opening of a new unit (*Newport*) or a reorganization and reallocation of beds and services (*Greenville*), is in keeping with HCFA's comparability principle which allows for exceptions and adjustments to assure that a hospital is not disadvantaged by unique circumstances in the base year that do not reflect its usual cost of operation. The Provider believes the events and resulting costs relating to its construction and renovation project satisfy the standards of 42 CFR 413.40(h) and the extraordinary circumstances requirement for granting an exception under 42 CFR 413.40(g) which states:

> (1) HCFA may adjust a hospital's operating cost . . . [for the Base Year] upward or downward as appropriate, under circumstances as specified in (g)(2) and (3) of this section.
>
> . . .

> (2) *Extraordinary circumstances.* The *hospital can show that it incurred unusual costs* (in either a cost reporting period subject to the ceiling or the hospital's base period) *due to extraordinary circumstances beyond its control.* These circumstances include, but are not limited to, strikes, fire, earthquakes, floods, or similar unusual occurrences with substantial cost affects. (Emphasis Added)

With respect to the intermediary's reliance on the Board's decision in *Sacred Heart Medical Center v. Aetna Life and Casualty Company,* PRRB Decision 89-D52, (August 1, 1989), the Provider argues that the Board had to uphold the Intermediary's determination in that case because of the stipulations made by the parties. In contemplation of an application for expedited judicial review, the parties in that case stipulated that the Board was bound by 52 CFR 412.71 and 412.72 and did not have the authority to rule in the Provider's favor with regard to its exception request. Accordingly the Board concluded that the Intermediary's determination was based on the proper application of the governing regulations by which it was bound.

In the instant case, the Provider has not entered into any stipulation with the Intermediary. Further, the Provider contends that 42 CFR 412.71 and 412.72, although applicable, cannot be read in a vacuum but must be applied within the context of the TEFRA adjustment under Section 1886(b)(4)(A) and its implementing regulation, 42 CFR 413.40. Whereas the parties in the *Sacred Heart case* stipulated that Section 1886(a)(2) of the Social Security Act was the authority for the adjustment requested, the Provider is relying on Section 1886((b)(4)(A) for the adjustment it seeks. Accordingly, the *Sacred Heart* decision is distinguishable from and is not dispositive of the case presented in this appeal.

In summary, the Provider is not requesting that the Board take any action which is not consistent with applicable law, regulation and the prior actions of HCFA in similar

cases. Based on the evidence submitted, the Provider submits that the Intermediary's refusal to consider the incremental operating costs associated with its construction and renovation project in the base year cost estimate, the target amount calculations and the resulting HSP, was arbitrary and capricious, an abuse of discretion, and otherwise not in accordance with law.

Intermediary's Contentions:

The Intermediary contends that the provisions of 42 CFR 412.71 and 412.72 provide the only authority for making any adjustment to the Provider's PPS base year costs. Since the Provider does not meet the requirements of these regulatory provisions, it is not entitled to an adjustment to base year costs in determining the HSP amount of the PPS rate. Pursuant to 42 CFR 412.71 and 412.72, an intermediary may be required to adjust the hospital's estimated base year inpatient operating costs to include certain modifications and adjustments as specified in these regulations. The regulations also require the intermediary to use the best available data at the time in estimating each hospital's base-year costs and the modifications thereto. In response to the Provider's argument that the Intermediary failed to use the best data available, the Intermediary contends that the Provider's position ignors the fact that it is "base year costs" that the Intermediary must estimate. The 1985 cost data which the Provider wants the Intermediary to consider has absolutely nothing to do with 1982 base year costs. The Intermediary asserts that the plain language of the applicable regulations and the essential purpose of PPS is that only costs actually incurred in the base year belong in the base year estimate. The Intermediary refers to the Preamble to the final PPS regulations in which HCFA explained the policy underlying the base year calculation as follows:

> . . . the proper scope of review of adjustments to base year costs is extremely narrow. Review will be

> limited to the question of whether the adjustments were made in accordance with the statute and regulations . . . . As to the amount of any adjustment, review will be limited to whether the intermediary was unreasonable and clearly erroneous in its assessment of the information then before it. The intermediary's judgment is entitled to substantial deference in these cases and should be subject to revision only in cases of egregious error. *Additional data, information, and arguments cannot properly be subsequently developed and presented during the review process, since such a procedure would be inconsistent with the requirement for a final determination prior to the beginning of the phase-in period based on the best available information.*

49 Fed. Reg. 259, Col. 3 (Jan. 3, 1984) (Emphasis Added)

The Intermediary stresses that there is no mechanism in the regulations that would allow the Intermediary to go back and adjust 1982 base year costs to include expenses incurred in 1985 as a result of the Provider's modernization program. Moreover, if the Provider's "best data available" argument was accepted, then an adjustment would be required for every cost center included in the base year since such information would have been available to the Intermediary prior to the hospital's entry into PPS on January 1, 1986. The Intermediary asserts that if adjustments for every fluctuation in cost were allowed during the transition period, this would defeat the prospective nature of PPS and would, in essence, put New York hospitals on a cost based system. Additionally, because of their participation in NYPHRM, this would give New York hospitals an unfair advantage over hospitals which entered into PPS in 1984 and did not have an extra two years to accumulate costs and have them added to the base year.

With respect to the Provider's reliance on Section 1886 (b)(4)(A) of the Social Securty Act and the provisions of 42 CFR 413.40, the Intermediary argues that those provisions only pertain to adjustments to the target amount for hospitals reimbursed under TEFRA and do not apply to the determination of the PPS payment rate. The Intermediary argues that the Provider has erroneously attempted to attach the adjustment provisions for the TEFRA target amount covered under Section 1886(b)(4)(A) to the PPS provisions in Section 1866(d)(1)(A) [*sic*]. It is the Provider's rationale that, since Section 1886(d)(1)(A) states that the PPS target amount shall be determined under section 1886(b)(3)(A) which covers the TEFRA target amount, then it must also incorporate Section 1886 (b)(4)(A) which provides for the "extraordinary circumstances" exception. The Intermediary argues that the PPS target amount expressly incorporates only the non-PPS target amount and does not expressly mention the exception provisions of Section 1886(b)(4)(A). Since Congress did not make express reference to (b)(4)(A), it did not intend to incorporate the "extraordinary circumstances" exception into the calculation of the PPS target amount. Moreover, even if such incorporation did occur, the governing regulations at 42 CFR 413.40 clearly indicate that they only apply to non-PPS hospitals.

The Intermediary further contends that, even if the provisions of 42 CFR 413.40 were applicable to PPS hospitals, the Provider has failed to prove that the costs at issue were beyond its control as required by 42 CFR 413.40(g)(2) which states:

> Extraordinary Circumstances. The provider can show that it incurred higher costs due to extraordinary circumstances beyond its control. These circumstances include, but are not limited to, strikes, fire, earthquake, or similar unusual occurrences with substantial cost effects.

Although the Provider alludes to the involvement of the Fire Department and the Joint Commission on Accreditation of Hospitals, it has furnished no proof that the construction activities were in response to mandates for corrections of violations which resulted in the incurrence of costs that were beyond its control. In the absence of such proof and the inability to show substantial cost effects due to extraordinary circumstances, the Provider does not meet the requirements for an exception even if the regulations did apply to the calculation of the PPS target amount.

With respect to the Provider's reliance on the determinations rendered for Newport Hospital (Exhibit J-Provider's Position Paper) and *Greenville Hospital System v. Bowen*, D.S.C. 1986, Civil Action No. 6:85-337-3, Sept. 16, 1986, Medicare and Medicaid Guide (CCH paragraph 35,880), the Intermediary contends that neither of these situations reflects HCFA's policy and, therefore, are not relevant to the Provider's case. Moreover, the facts in both of those cases do not apply because the adjustments which were effected involved base year data and were not based on costs incurred after the base year. The Intermediary asserts that the governing decision in this case is PRRB Decision 89-D52, *Sacred Heart Medical Center v. Aetna Life and Casualty Company*, (August 1, 1989), wherein the Board held that 42 CFR 412.71 and 412.72 are the controlling provisions. Since the Provider does not qualify for an adjustment under these applicable regulations, the Intermediary believes its position should be upheld.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law—Title XVIII of the Social Security Act:

(a) Section 1861(v)(1)(A) — Reasonable Cost
(b) Section 1886 — Payment to Hospitals for Inpatient Hospital Services

2. Regulations—42 CFR 412, Subpart E:

(a) 412.70	— Determination of Transition Period Payment Rates—General Description
(b) 412.71	— Determination of Base-Year Costs
(c) 412.72	— Modification of Base-Year Costs

3. Regulations—42 CFR 413, Subpart C

413.40	— Ceiling on Rate of Hospital Cost Increases

FINDINGS AND CONCLUSIONS:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing and post-hearing briefs, finds and concludes that the provisions of 42 CFR 412.71 and 412.72 are the controlling regulations which must be applied in determining whether the Provider is entitled to an adjustment to its hospital-specific rate retroactive to the beginning of its first year under the prospective payment system. These regulations establish specific requirements for a hospital's timely submission of an adjustment request and supporting documentation and further specify the types of modifications which shall be considered by the intermediary in making adjustments to base year costs. Since the costs for which relief is being sought by the Provider were not incurred in the base year, the Provider is not entitled to an adjustment to its PPS rate for fiscal year 1986. It is the Board's conclusion that the Intermediary's determination is based on the proper application of the governing regulations by which the Board is bound.

DECISION:

The Provider is not entitled to an adjustment to its hospital-specific rate retroactive to the beginning of the Provider's first year under the prospective payment system. The Intermediary's determination is affirmed.

Board Members Participating:

Elise D. Smith
Arthur P. Owens
Keith E. Braganza
Sally A. Kirkpatrick

FOR THE BOARD:

Jun 6, 1990

/s/ Elise D. Smith
ELISE D. SMITH
Chairman

APPENDIX H

Provider Reimbursement Review Board
Hearing Decision
90-D28

Provider No. 33-0290

PROVIDER—ST. VINCENT'S HOSPITAL AND MEDICAL CENTER OF NEW YORK
New York, NY

VS

INTERMEDIARY—BLUE CROSS AND BLUE SHIELD ASSOCIATION/EMPIRE BLUE CROSS AND BLUE SHIELD

Date of Hearing—December 15, 1989
Cost Reporting Period Ended—December 31, 1986
Case No. 86-7020R

ISSUE:

Whether the Provider is entitled to an adjustment to its hospital-specific rate retroactive to the beginning of the Provider's first year under the prospective payment system?

SUMMARY OF FACTS:

The Provider is a 770-bed, not-for-profit hospital located in New York City, New York. In the late 1970s and early 1980s, the Provider undertook a major construction and renovation program which was not completed until 1984. Although the construction program did not change the number of certified beds, the Provider's square footage increased by 21 percent and the number of full time equiva-

lent employees increased from 2,989 in 1982 to 3,155 in 1985. During the period of January 1, 1983, through December 31, 1985, the Provider was reimbursed pursuant to the New York Prospective Hospital Reimbursement Methodology (NYPHRM) which exempted New York hospitals from the general principles of Medicare reimbursement. Because of NYPHRM, the Provider did not enter into Medicare's prospective payment system (PPS) until January 1, 1986, which was two years later than most hospitals in the United States.

As a result of the major renovation and construction project, the Provider sought and obtained an increase in its reimbursement rate under the NYPHRM waiver for increased operating costs incurred after its 1982 base period and before its entry into PPS. However, since the incremental operating costs associated with the expanded facility were not incurred during the 1982 base period, the Intermediary's determination of the hospital-specific portion (HSP) of the Provider's PPS rate for fiscal year 1986 did not include these costs. During 1985, the Provider made a request to the Intermediary for an adjustment to its target amount calculation based upon the incremental operating costs approved under the NYPHRM waiver. On December 13, 1985, the Intermediary issued its Final Revised Notice of Base Period Costs and Target Amount and did not include the requested increase in operating costs for the Provider's modernization program. The Provider filed an appeal with the Provider Reimbursement Review Board (Board) pursuant to 42 CFR 405.1835ff and has met the jurisdictional requirements therein. The estimated amount of Medicare reimbursement in controversy is $1,400,000.

Provider's Contentions:

The Provider contends that the Intermediary has ignored Congress' directive that the base year cost estimate must be comparable to the cost a hospital would be expected

to incur during the PPS transition period. To ensure comparability, Congress expected the Intermediary to use the best data available at the time the base year estimation was made and mandated exceptions and adjustments to the base year estimate for extraordinary circumstances or other events causing significant distortions. The Provider asserts that this mandate is clearly presented in Section 1886(b)(4)(A) of the Social Security Act which states:

> The Secretary *shall provide for an exemption* from, or an *exception* and *adjustment* to, the method under this subsection for determining the amount of payment to a hospital *where events beyond the hospital's control or extraordinary circumstances,* including changes in the case mix of such hospital, *create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured).* (Emphasis Added)

In keeping with congressional intent, the Health Care Financing Administration (HCFA) acknowledged its statutory obligation to make adjustments to the base year estimate as indicated by the following excerpt from the Preamble to the final PPS regulations:

> We believe the Congress intended to assure, by giving us broad authority under the law to provide for exceptions, exclusions and adjustments, that some hospitals are not advantaged or disadvantaged by unique circumstances in their base year that do not reflect their usual cost of operation per case. This intent is indicated in Section 1886(b)(4)(A) of the Act.

49 Fed. Reg. 261 (Jan. 3, 1984)

Thus, the Provider contends that, as early as January 3, 1984, HCFA acknowledged that Section 1886(b)(4)(A) was the statutory authority for PPS base year modifications as implemented through the provisions of 42 CFR

412.71 and 412.72. It is the Intermediary's failure to abide by these statutory requirements which led to the Provider's appeal in this case.

The Provider further contends that the Intermediary did not use the best data available at the time it estimated the hospital's base year cost as required by 42 CFR 412.71 (d). Since Congress did not limit the "best data available" to costs or events occurring only in the base year, it is the Provider's position that the Intermediary's restrictive application of this requirement ignores reliable and uncontrovertible data which was available in 1985, the year prior to entry into PPS. Moreover, the available data revealed the unique circumstances which resulted in significant distortions between the Provider's base year estimate and the actual costs which would be incurred in the transition period. The Provider argues that this point was recognized in *Greenville Hospital System v. Bowen,* D.S.C. 1986, Civil Action No. 6:85-337-3, Sept. 16, 1986, Medicare & Medicaid Guide (CCH paragraph 35,880), wherein the court emphasized this important principle as follows:

> Congress clearly intended, and the Secretary has recognized, that the "best data available" was not to be strictly limited to data from the base year cost report but was also to include estimates needed to take into account changes between operating costs in the base year and operating costs under PPS that were known to exist at the time the rates were calculated.

The Provider asserts that when the Intermediary estimated the base year costs and determined the HSP amount in 1985, it had full knowledge of the increased operating costs which resulted from the renovation and construction project. However, rather than give consideration to this reliable data available to it for the years 1982-1985, the Intermediary took a rigid and statutorily improper position of considering only costs reported in 1982. The Intermediary's action disregarded congressional intent and abrogated its statutory obligation to use the "best data available" as

required under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

The Provider also contends that the Intermediary should have considered and granted an "exemption from, or an exception and adjustment" under the TEFRA adjustment provisions of Section 1886(b)(4)(A) of the Act in determining the PPS target amount. Pursuant to Section 1886(d)(1)(A)(i)(I) of Act, the amount of payment for inpatient hospital services during the PPS transition period is determined by blending the federal rate and the hospital's TEFRA target amount, as defined in Section 1886(b)(3)(A) of the Act. In accordance with Section 1886(b)(3)(A), the TEFRA target amount is calculated by multiplying the allowable operating costs of inpatient hospital services for the preceding 12-month cost reporting period by the applicable percentage increase. Since the PPS provisions of Section 1886(d)(1)(A)(i)(I) and (ii)(I) cross-refer to and incorporate by express reference the TEFRA target amount determined under section 1886(b)(3)(A), the target amount cannot be calculated without considering and, where appropriate, making the required exemption, exception or adjustment under subsection (b)(4)(A). In the absence of any express exclusion, it is the Provider's contention that the requirements of Section 1886(b)(4)(A) must be applied under established principles of statutory construction in determining the PPS target amount and resulting HSP under Section 1886(d)(1)(A).

The Provider asserts that HCFA has actually granted such TEFRA adjustments to other PPS hospitals which had requested an adjustment of base year costs after undergoing a substantial change in their facilities and/or services prior to their entry into PPS. In each of those cases, HCFA granted a TEFRA adjustment under Section 1886(b)(4)(A) and its implementing regulation 42 CFR 413.40, and effected a PPS base year modification pursuant to 42 CFR 412.71 and 412.72, which is the same adjustment the

Provider is requesting in this case. In reference to the relief granted by HCFA to Newport Hospital in Arkansas (Exhibit J—Provider's Position Paper), the Provider notes that a new facility was built after the old one failed to meet life safety code requirements. Newport Hospital opened its new facility approximately 4½ months after the start of its base year. HCFA recognized that a distortion of cost existed between the base year estimate and the costs expected to be incurred from operations at the new facility and granted a base year adjustment under 42 CFR 405.463(h) (recodified as 42 CFR 413.4(h)). A corresponding prospective adjustment was also made to Newport Hospital's HSP under 42 CFR 412.72 for PPS purposes. In addition, HCFA used actual, post-base year costs to determine the adjustment necessary to ensure that the base year estimate and PPS target amount calculation were comparable to Newport Hospital's actual costs of operations.

In a similar case involving Greenville Hospital System (GHS) in South Carolina, where two hospitals underwent a reorganization after the close of the PPS base year but prior to entry into PPS, HCFA also adjusted GHS's operating costs under 42 CFR 405.463(h) to reflect changes that had occurred to the base year costs (Provider's Exhibit M). In applying the TEFRA adjustment to these two hospitals, HCFA cited the following rationale:

> We have . . . decided to treat your request as an application for an *adjustment* to GHS's cost per case for the cost reporting period subject to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), as authorized by regulation 405.463(h) [*recodified* as 413.40(h)]. Under that regulation, HCFA may adjust operating costs considered in establishing a hospital's TEFRA-year cost per case to *take into account factors which could result in a significant distortion in the operating costs of inpatient hospital services.* Because of the substantial magnitude of the

> costs affected by the Greenville realignment, we have determined that a significant distortion in GHS's operating costs would exist without an adjustment, and *we are therefore, granting the adjustment* described below [for PPS purposes].
>
> As you know, the amount of the hopsital-specific portion (HSP) of PPS payment is determined by reference to each hospital's target amount under TEFRA. (Emphasis Added)

The Provider notes that, as in the Newport Hospital case, after making the TEFRA adjustment, HCFA prospectively adjusted the estimate of base year costs and the PPS target amount pursuant to 42 CFR 412.72.

In further support of its position, the Provider also cites the case involving *Redbud Hospital District v. Heckler,* C-84-4382-MHP, (N.D. Cal., 1984). Although the provider in *Redbud* was forced to litigate to obtain an adjustment to correct the distortion in the calculation of base year costs and target amount, the Provider notes that HCFA did not dispute that Section 1886(b)(4)(A) of the Social Security Act authorized adjustments to the HSP calculation for PPS purposes. The Provider contends that the Intermediary has failed to advance a legally supportable argument or introduce any relevant evidence against the legal and reimbursement principles applied by HCFA in *Newport, Greenville* and *Redbud.*

The Provider also contends that the construction and renovation project which it undertook was necessary to correct substantial deficiencies which threatened the licensure and accreditation of its previous facility. Thus, it had no choice but to renovate its old facilities or construct new ones when renovation would have been inadequate. The regulations at 42 CFR 413.40(h), which were applied by HCFA in granting the TEFRA adjustment in *Newport* and *Greenville,* state the following:

> Adjustments—(1) *Comparability of cost reporting periods* (i) *HCFA may adjust the amount of the operating costs* considered in establishing cost per case for one or more cost reporting periods, including both periods subject to the ceiling and the hospital's base period, *to take into account factors that could result in a significant distortion in the operating costs of inpatient hospital services.* The adjustments include, but are not limited to, adjustments of the base period costs to include explicitly FICA taxes (if the hospital did not incur costs for FICA taxes in its base period), and services billed under Part B of Medicare during the base period, but paid under Part A during the subject cost reporting period. (Emphasis Added)

The application of the significant distortion in operation factor, i.e. the opening of a new unit (*Newport*) or a reorganization and reallocation of beds and services (*Greenville*), is in keeping with HCFA's comparability principle which allows for exceptions and adjustments to assure that a hospital is not disadvantaged by unique circumstances in the base year that do not reflect its usual cost of operation. The Provider believes the events and resulting costs relating to its construction and renovation project satisfy the standards of 42 CFR 413.40(h) and the extraordinary circumstance requirement for granting an exception under 42 CFR 413.40(g) which states:

> (1) HCFA may adjust a hospital's operating cost . . . [for the Base Year] upward or downward as appropriate, under circumstances as specified in (g)(2) and (3) of this section.
>
> . . .
>
> (2) *Extraordinary circumstances.* The *hospital can show that it incurred unusual costs* (in either a cost reporting period subject to the ceiling or the hospital's base period) *due to extraordinary circumstances beyond its control.* These circumstances in-

clude, but are not limited to, strikes, fire, earthquakes, floods, or similar unusual occurrences with substantial cost affects. (Emphasis Added)

With respect to the Intermediary's reliance on the Board's decision in *Sacred Heart Medical Center v. Aetna Life and Casualty Company,* PRRB Decision 89-D52, (August 1, 1989), the Provider argues that the Board had to uphold the Intermediary's determination in that case because of the stipulations made by the parties. In contemplation of an application for expedited judicial review, the parties in that case stipulated that the Board was bound by 42 CFR 412.71 and 412.72 and did not have the authority to rule in the Provider's favor with regard to its exception request. Accordingly the Board concluded that the Intermediary's determination was based on the proper application of the governing regulations by which it was bound.

In the instant case, the Provider has not entered into any stipulation with the Intermediary. Further, the Provider contends that 42 CFR 412.71 and 412.72, although applicable, cannot be read in a vacuum but must be applied within the context of the TEFRA adjustment under Section 1886(b)(4)(A) and its implementing regulation, 42 CFR 413.40. Whereas the parties in the *Sacred Heart* case stipulated that Section 1886(a)(2) of the Social Security Act was the authority for the adjustment requested, the Provider is relying on Section 1886(b)(4)(A) for the adjustment it seeks. Accordingly, the *Sacred Heart* decision is distinguishable from and is not dispositive of the case presented in this appeal.

In summary, the Provider is not requesting that the Board take any action which is not consistent with applicable law, regulation and the prior actions of HCFA in similar cases. Based on the evidence submitted, the Provider submits that the Intermediary's refusal to consider the incremental operating costs associated with its construction and renovation project in the base year cost estimate, the

target amount calculation and the resulting HSP, was arbitrary and capricious, an abuse of discretion, and otherwise not in accordance with law.

Intermediary's Contentions:

The Intermediary contends that the provisions of 42 CFR 412.71 and 412.72 provide the only authority for making any adjustment to the Provider's PPS base year costs. Since the Provider does not meet the requirements of these regulatory provisions, it is not entitled to an adjustment to base year costs in determining the HSP amount of the PPS rate. Pursuant to 42 CFR 412.71 and 412.72, an intermediary may be required to adjust the hospital's estimated base year inpatient operating costs to include certain modifications and adjustments as specified in these regulations. The regulations also require the intermediary to use the best available data at the time in estimating each hospital's base-year costs and the modifications thereto. In response to the Provider's argument that the Intermediary failed to use the best data available, the Intermediary contends that the Provider's position ignores the fact that it is "base year costs" that the Intermediary must estimate. The 1985 cost data which the Provider wants the Intermediary to consider has absolutely nothing to do with 1982 base year costs. The Intermediary asserts that the plain language of the applicable regulations and the essential purpose of PPS is that only costs actually incurred in the base year belong in the base year estimate. The Intermediary refers to the Preamble to the final PPS regulations in which HCFA explained the policy underlying the base year calculation as follows:

> . . . the proper scope of review of adjustments to base year costs is extremely narrow. Review will be limited to the question of whether the adjustments were made in accordance with the statute and regulations. . . . As to the amount of any adjustment,

> review will be limited to whether the intermediary was unreasonable and clearly erroneous in its assessment of the information then before it. The intermediary's judgment is entitled to substantial deference in these cases and should be subject to revision only in cases of egregious error. *Additional data, information, and arguments cannot properly be subsequently developed and presented during the review process, since such a procedure would be inconsistent with the requirement for a final determination prior to the beginning of the phase-in period based on the best available information.*

49 Fed. Reg. 259, Col. 3 (Jan. 3, 1984) (Emphasis Added)

The Intermediary stresses that there is no mechanism in the regulations that would allow the Intermediary to go back and adjust 1982 base year costs to include expenses incurred in 1985 as a result of the Provider's modernization program. Moreover, if the Provider's "best data available" argument was accepted, then an adjustment would be required for every cost center included in the base year since such information would have been available to the Intermediary prior to the hospital's entry into PPS on January 1, 1986. The Intermediary asserts that if adjustments for every fluctuation in cost were allowed during the transition period, this would defeat the prospective nature of PPS and would, in essence, put New York hospitals on a cost based system. Additionally, because of their participation in NYPHRM, this would give New York hospitals an unfair advantage over hospitals which entered into PPS in 1984 and did not have an extra two years to accumulate costs and have them added to the base year.

With respect to the Provider's reliance on Section 1886 (b)(4)(A) of the Social Security Act and the provisions of 42 CFR 413.40, the Intermediary argues that those provisions only pertain to adjustments to the target

amount for hospitals reimbursed under TEFRA and do not apply to the determination of the PPS payment rate. The Intermediary argues that the Provider has erroneously attempted to attach the adjustment provisions for the TEFRA target amount covered under Section 1886(b)(4)(A) to the PPS provisions in Section 1866 (d)(1)(A) [*sic*]. It is the Provider's rationale that, since Section 1886(d)(1)(A) states that the PPS target amount shall be determined under section 1886(b)(3)(A) which covers the TEFRA target amount, then it must also incorporate Section 1886(b)(4)(A) which provides for the "extraordinary circumstances" exception. The Intermediary argues that the PPS target amount expressly incorporates only the non-PPS target amount and does not expressly mention the exception provisions of Section 1886(b)(4)(A). Since Congress did not make express reference to (b)(4)(A), it did not intend to incorporate the "extraordinary circumstances" exception into the calculation of the PPS target amount. Moreover, even if such incorporation did occur, the governing regulations at 42 CFR 413.40 clearly indicate that they only apply to non-PPS hospitals.

The Intermediary further contends that, even if the provisions of 42 CFR 413.40 were applicable to PPS hospitals, the Provider has failed to prove that the costs at issue were beyond its control as required by 42 CFR 413.40(g)(2) which states:

> Extraordinary Circumstances. The provider can show that it incurred higher costs due to extraordinary circumstances beyond its control. These circumstances include, but are not limited to, strikes, fire, earthquake, or similar unusual occurrences with substantial cost effects.

Although the Provider alludes to the involvement of the Fire Department and the Joint Commission on Accreditation of Hospitals, it has furnished no proof that the construction activities were in response to mandates for cor-

rections of violations which resulted in the incurrence of costs that were beyond its control. In the absence of such proof and the inability to show substantial cost effects due to extraordinary circumstances, the Provider does not meet the requirements for an exception even if the regulations did apply to the calculation of the PPS target amount.

With respect to the Provider's reliance on the determinations rendered for Newport Hospital (Exhibit J—Provider's Position Paper) and *Greenville Hospital System v. Bowen*, D.S.C. 1986, Civil Action No. 6:85-337-3, Sept. 16, 1986, Medicare and Medicaid Guide (CCH paragraph 35,880), the Intermediary contends that neither of these situations reflects HCFA's policy and, therefore, are not relevant to the Provider's case. Moreover, the facts in both of those cases do not apply because the adjustments which were effected involved base year data and were not based on costs incurred after the base year. The Intermediary asserts that the governing decision in this case is PRRB Decision 89-D52, *Sacred Heart Medical Center v. Aetna Life and Casualty Company*, (August 1, 1989), wherein the Board held that 42 CFR 412.71 and 412.72 are the controlling provisions. Since the Provider does not qualify for an adjustment under these applicable regulations, the Intermediary believes its position should be upheld.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law—Title XVIII of the Social Security Act:

(a) Section 1861(v)(1)(A)	— Reasonable Cost
(b) Section 1886	— Payment to Hospitals for Inpatient Hospital Services

2. Regulations—42 CFR 412, Subpart E:

(a) 412.70	— Determination of Transition Period Payment Rates—General Description

(b) 412.71	— Determination of Base-Year Costs
(c) 412.72	— Modification of Base-Year Costs

3. Regulations—42 CFR 413, Subpart C

413.40	— Ceiling on Rate of Hospital Cost Increases

FINDINGS AND CONCLUSIONS:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing and post-hearing briefs, finds and concludes that the provisions of 42 CFR 412.71 and 412.72 are the controlling regulations which must be applied in determining whether the Provider is entitled to an adjustment to its hospital-specific rate retroacitve to the beginning of its first year under the prospective payment system. These regulations establish specific requirements for a hospital's timely submission of an adjustment request and supporting documentation and further specify the types of modifications which shall be considered by the intermediary in making adjustments to base year costs. Since the costs for which relief is being sought by the Provider were not incurred in the base year, the Provider is not entitled to an adjustment to its PPS rate for fiscal year 1986. It is the Board's conclusion that the Intermediary's determination is based on the proper application of the governing regulations by which the Board is bound.

DECISION:

The Provider is not entitled to an adjustment to its hospital-specific rate retroactive to the beginning of the Provider's first year under the prospective payment system. The Intermediary's determination is affirmed.

Board Members Participating:

Elise D. Smith
Arthur P. Owens
Keith E. Braganza
Sally A. Kirkpatrick

FOR THE BOARD:

Jun 6, 1990

/s/ Elise D. Smith
ELISE D. SMITH
Chairman

APPENDIX I

PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION
ON THE RECORD
91-D26

Provider No. 44-0167

PROVIDER—WEST SIDE HOSPITAL
NASHVILLE, TN

VS

INTERMEDIARY—BLUE CROSS AND BLUE SHIELD
ASSOCIATION/BLUE CROSS AND BLUE SHIELD
OF TENNESSEE

Date of Hearing—January 31, 1991
Cost Reporting Period Ending
April 30, 1985
Case No. 89-0817

ISSUE:

Whether emergency room standby costs related to hospital inpatients should be included in the base year costs used to compute the hospital-specific prospective payment rate?

SUMMARY OF FACTS:

The Provider is a 195-bed, proprietary, acute care hospital owned by Hospital Corporation of America. For the fiscal year ended April 30, 1985, the Provider's first

transition year under the prospective payment system (PPS), the Provider appealed the Intermediary's determination of the hospital-specific portion (HSP) of its prospective payment rate. The Provider filed its appeal with the Provider Reimbursement Review Board (Board) pursuant to 42 CFR 405.1835ff and has met the jurisdictional requirements therein.

In July 1983, the Provider opened an emergency room and began incurring standby costs under contractual arrangements entered into with emergency room physicians. The Provider's base year for PPS reimbursement was the fiscal year ended April 30, 1983. Therefore, the inpatient portion of the physician's standby costs was not included in the Provider's HSP rate. In its cost report for the fiscal year ended April 30, 1985, its first year under the PPS, the Provider identified $200,543 as physician standby costs with a Medicare reimbursement effect of approximately $68,500. The Intermediary disallowed the protested amount included in the cost report based on the application of 42 CFR 412.71 and 412.72.

Provider's Contentions:

The Provider contends that its HSP rate should be adjusted to reflect the cost of new services incurred after the base year. In support of its position, the Provider cites the federal district court decision in *Redbud Hospital District v. Heckler*, C-84-4382-MHP, (N.D. Cal., 1984). In that decision, the court found that the Secretary had a clear duty to consider all extraordinary circumstances which distort the reimbursement rate in accordance with Section 1886(b)(4)(A) of the Social Security Act which reads in part as follows:

> The Secretary shall provide for an exemption from, or an exception and adjusment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, in-

cluding changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured).

Under the *Redbud* decision, the Secretary was enjoined from imposing PPS on the hospital until adjustments were made to its HSP rate to account for increased costs resulting from additions to the facility after its base year. The Provider believes its circumstances closely parallel the circumstances in the *Redbud* case, and that the Intermediary has an obligation to follow congressional intent to adjust its base year costs for extraordinary and unusual costs not recognized in the HSP rate.

The Provider argues that the regulations at 42 CFR 412.71(b) provide for modifications to base year costs to include and/or exclude costs which may distort the amount of payment received by a hospital. The Provider notes that a hospital's base year costs are routinely adjusted to exclude one-time nonrecurring costs in the base year. It is logical not to reimburse a hospital year-after-year based on a rate which includes nonrecurring costs. However, it is arbitrary and illogical that a hospital be reimbursed year-after-year based on a rate whbich does not include costs that are incurred year-after-year. It is the Provider's position that Congress did not intend to freeze or curtail the addition of new services which may be needed in the hospital's service area and thus limit Medicare beneficiaries' access to proper care. Moreover, there is no indication that Congress intended to limit the services a provider could offer to only those offered in a particular designated twelve-month period (i.e., the base year).

The Provider further argues that the regulations at 42 CFR 412.71(c) allow hospitals to request an adjustment to base year costs and that the Intermediary has the authority to allow for an increase based on estimated

payments in certain cases. Since the increased costs being sought are based on an actual contractual arrangement rather than an estimated amount, the Provider believes the Intermediary should certainly be able to increase the base year rate to take into account a new service actually being provided by the hospital. As to whether the HSP rate should be revised retroactively, the Provider refers to the Health Care Financing Administration (HCFA) Ruling 89-1 and regulation 42 CFR 412.72(a)(4)(i) and (ii) which mandate that adjustments or modifications to base year costs be effected retroactively in various instances. The Provider believes that it meets the guidelines discussed in HCFA Ruling 89-1 and, therefore, its HSP rate should be revised retroactively to the beginning of PPS and throughout the transition period.

Intermediary's Contentions:

The Intermediary contends that, under the provisions of 42 CFR 412.71 and 412.72, the Provider is not entitled to a change in the base year costs used to compute its HSP prospective payment rate. The provisions of 42 CFR 412.71 clearly describe the specific modifications which can be made to a provider's base year costs. The Intermediary asserts that emergency room standby cost does not qualify as one of the listed specific modifications permitted under subsections (b) and (c) of 42 CFR 412.71. The Intermediary argues that the ruling provision is 42 CFR 412.71(d) which states:

> The intermediary will use the best data available at the time in estimating each hospital's base year costs and the modifications to those costs authorized by paragraphs (b) and (c) of this section. The intermediary's estimate of base year costs and modifications thereto is final and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983, expect as provided in 412.72.

It is the Intermediary's position that it did use the best available data at the time of the audit and that the financial records did not contain any costs for emergency room physicians. In addition, the HCFA Form 1008 filed by the Provider, which allows for modifications listed in 42 CFR 412.71(b) and (c) was silent on the matter of emergency room physician standby fees. The Intermediary further notes that the regulations state that its estimate is final and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983, except as provided in 42 CFR 412.72.

The Intermediary points out that changes to the base-year costs are examined in 42 CFR 412.72 and five different circumstances are presented for which a provider's base year costs can be modified: (1) inadvertent omissions; (2) correction of mathematical errors of calculations; (3) recognition of additional costs; (4) successful appeal; and (5) unlawfully claimed costs. The Intermediary argues that none of the above-described situations apply to this case. Moreover, even if the Provider was successful in its appeal in this case, the successful appeal proviso under number 4 above would only be appropriate for modifications made under 42 CFR 412.71(b). As previously argued, the Provider's emergency room physician standby costs were not a feasible modification under that regulation.

In summary, the Intermediary concludes that its determination should be upheld based on the following:

> The appealed cost item does not meet the criteria which is set forth in 42 CFR 412.72, for the modification of base year costs.
>
> The allowability of the Provider's base year costs is governed by 42 CFR 412.71(d). Any decision favorable to the Provider would have to be based upon data that was not previously presented to the Intermediary. Therefore, the regulatory requirements that would warrant modification of the Provider's base year costs have not been satisfied.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law—Title XVIII of the Social Security Act:

(a) Section 1861(v)(1)(A)	— Reasonable Cost
(b) Section 1886	— Payment to Hospitals for Inpatient Hospital Services

2. Regulations—42 CFR 412, Subpart E:

(a) 412.70	— Determination of Transition Period Payment Rates—General Description
(b) 412.71	— Determination of Base-Year Costs
(c) 412.72	— Modification of Base-Year Costs

FINDINGS AND CONCLUSIONS:

The Board, after consideration of the facts, parties' contentions, and evidence submitted finds and concludes that the provisions of 42 CFR 412.71 and 412.72 are the controlling regulations which must be applied in determining whether the Provider is entitled to an adjustment to its hospital-specific rate retroactive to the beginning of its first year under the prospective payment system. These regulations establish specific requirements for a hospital's timely submission of an adjustment request and supporting documentation. They further specify the types of modifications which shall be considered by the intermediary in making adjustments to base year costs. Since the costs for which relief is being sought by the Provider were not incurred in the base year, the Provider is not entitled to an adjustment to its PPS rate for fiscal year 1985. The Board concludes that the Intermediary's determination is based on the proper application of the governing regulations.

DECISION:

The emergency room standby costs related to hospital inpatients should not be included in the base year costs used to compute the hospital-specific prospective payment rate. The Intermediary's determination is affirmed.

Board Members Participating:

Arthur P. Owens
Keith E. Braganza
Sally A. Kirkpatrick
Joseph F. Sloan

FOR THE BOARD:

Mar. 4, 1991

/s/ Arthur P. Owens
ARTHUR P. OWENS
Acting Chairman

APPENDIX J

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 91-5401

THE METHODIST HOSPITAL, *et al.*

v.

DONNA SHALALA, SECRETARY OF HHS,
Appellant

and Consolidated Cases

BEFORE: Buckley, D. H. Ginsburg and Henderson, Circuit Judges

ORDER

[Filed Nov. 16, 1993]

Upon consideration of the petition for rehearing of plaintiffs/appellees, filed October 29, 1993, it is

ORDERED, by the Court, that the petition is denied.

Per Curiam
FOR THE COURT:
RON GARVIN
Clerk

By: /s/ Robert A. Bonner
ROBERT A. BONNER
Deputy Clerk

APPENDIX K

SUPREME COURT OF THE UNITED STATES

No. A-645

THE METHODIST HOSPITAL,
ST. VINCENT'S HOSPITAL, ETC., *et al.*,
Petitioners

v.

DONNA E. SHALALA, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

ORDER

UPON CONSIDERATION of the application of counsel for the petitioner,

IT IS ORDERED that the time for filing a petition for a writ of certiorari in the above-entitled case, be and the same is hereby, extended to and including March 16, 1994.

/s/ William H. Rehnquist
Chief Justice of the
United States

Dated this 3rd day of February, 1994.

APPENDIX L

FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

Civil Action No. 6:85-337-3

IN THE MATTER OF THE APPLICATION OF

ST. VINCENT'S HOSPITAL AND MEDICAL CENTER OF NEW YORK, THE METHODIST HOSPITAL, NYACK HOSPITAL and the BROOKLYN HOSPITAL-CALEDONIAN HOSPITAL,
Petitioners,

v.

GREENVILLE HOSPITAL SYSTEM and
LOUIS SULLIVAN, M.D., as Secretary of
Health and Human Services,
Respondents.

In Re *Greenville Hospital System v. Bowen*
(D.S.C. 1986)

ORDER

[Filed Dec. 11, 1989]

This matter came before me upon the Application of the Petitioners to unseal the Stipulation, Settlement Agreement and related Settlement Documents which were sealed by this Court by Order dated December 17, 1986.

Upon consideration of Petitioner's Motion, Memoranda and supporting Affidavit and accompanying documents, together with the Memorandum filed in opposition to the Motion by Respondent The Secretary of Health and Hu-

man Services and oral argument of counsel, I hereby grant Petitioner's Motion.

Petitioner's Motion is based upon its common law and First Amendment right of access.

Under common law, there is a presumption of access accorded to judicial records; however, this presumption can be rebutted if countervailing interests heavily outweigh the public interests in access. *Rushford v. New Yorker Magazine, Inc.*, 846 F.2d 249, 253 (4th Cir. 1988). The burden of showing some significant interest that outweighs the presumption of access is upon the party oppossing access. *Rushford, supra,* at p. 253 citing *Bank of America Nat'l Trust v. Hotel Rittenhouse,* 800 F.2d 339, 344 (3d Cir. 1986).

Under the First Amendment, the party opposing access has a more rigorous burden of showing that the denial serves an important governmental interest and that there is no less restrictive way to serve that governmental interest. *Rushford, supra,* at 253.

In this case, I find that the Respondent opposing Petitioner's Motion has presented the Court no legally sufficient reason for the continued closure of the documents sought by Petitioner. See *Wilson v. American Motors Corp.*, 759 F.2d 1568, 1571-72 (11th Cir. 1985) (fn. 4, Although courts should encourage settlements, the payment of money to a party is simply not a compelling governmental interest. Furthermore, denial of access on the ground that it might adversely affect the party opposing access in other judicial proceedings is contrary to the most basic principles of American jurisprudence); see also *Bank of America Nat'l Trust v. Hotel Rittenhouse,* 800 F.2d 339, 346 (3d Cir. 1986) (the generalized interest in encouraging settlements does not rise to the level of interest that outweighs the public's common law right of access).

IT IS THEREFORE ORDERED that Petitioner's Motion be granted and that Petitioners be afforded access

and the opportunity to examine, inspect and make copies of the Stipulation, Settlement Agreement and related Settlement Documents which were sealed by this Court by Order dated December 17, 1986.

AND IT IS SO ORDERED.

Dated: December 11, 1989

/s/ G. Ross Anderson, Jr.
HONORABLE G. ROSS ANDERSON, JR.
United States District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

Civil Action No. 6:85-337-3

GREENVILLE HOSPITAL SYSTEM, d/b/a
GREENVILLE HOSPITAL CENTER and
GREENVILLE GENERAL HOSPITAL,
Plaintiffs,

v.

OTIS R. BOWEN, M.D.,
Secretary of Health and Human Services,
Defendant.

STIPULATION AND AGREEMENT UNDER SEAL

[Filed Dec. 16, 1986]

This Stipulation is made by and between Greenville Hospital System, d/b/a Greenville Hospital Center and Greenville General Hospital ("Greenville"), and the Secretary of Health and Human Services ("the Secretary").

1. The Secretary administers the Medicare program under title XVIII of the Social Security Act, 42 U.S.C. § 1395, *et seq.*, through the Health Care Financing Administration (HCFA), and using the services of contractors known as fiscal intermediaries. Greenville Hospital System operates Greenville Hospital Center and Greenville General Hospital, both of which participate as providers of services under the Medicare program. 42 U.S.C. § 1395x(u).

2. Pursuant to Pub. L. 98-21, most Medicare provider hospitals, including GHC and GGH, became subject to the prospective payment system (PPS) effective with cost

reporting periods beginning on or after October 1, 1983. 42 U.S.C. § 1395ww. Under PPS, Medicare payment for the operating costs of inpatient hospital services is based on prospectively determined rates which are applied to each hospital "discharge" to determine the amount of payment. Beginning with the fifth year under the new system, payment will be based entirely on a nationally applicable rate. 42 U.S.C. § 1395ww(d)(3). However during the first four "transition" years a declining portion of the rate, known as the "hospital-specific" portion, is based on a hospital's own cost experience in a base year. 42 U.S.C. § 1395ww(d)(1)(A); 42 C.F.R. § 412.70.

3. On August 11, 1983, Greenville received from its intermediary, Blue Cross and Blue Shield of South Carolina ("Blue Cross"), a notice of what its PPS rate (including the hospital-specific rate) would be for the first PPS transition year. Greenville objected to the rate because it was based on the costs incurred by GHC and GGH in the base year, ending October 3, 1982, and did not reflect a transfer of beds, services, and interns and residents between the two hospitals after the close of the base year, but before Blue Cross calculated the rate.

4. The Administrator of HCFA, by an undated letter received by Greenville's counsel on May 2, 1984, attached as Exhibit H to the complaint in this case, agreed to make an adjustment to Greenville's rates, based on authority contained in regulations implementing the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The Administrator advised Greenville that under the regulation presently codified at 42 C.F.R. § 412.72(a)(3), the adjustment would only be applied prospectively, and would not be made for the first PPS transition year.

5. On February 4, 1985, Greenville filed this action seeking to require the Secretary to apply the adjustment to the first PPS transition year.

6. On Septemberf 16, 1986, the United States District Court for the District of South Carolina, Greenville Divi-

sion, granted Greenville's motion for summary judgment, and ordered the Secretary to apply the adjustment to Greenville's first PPS year, and to pay Greenville the amount resulting from application of the adjustment, with interest in accordance with 42 U.S.C. § 1395oo(f)(2). Judgment was entered on September 18, 1986.

The parties desire to settle this case on the following basis:

7. In consideration of the Secretary's actions described in paragraph 9, below, Greenville agrees to join with the Secretary in a stipulation of dismissal of this action with prejudice pursuant to Fed. R. Civ. P. 41(a), and in a motion to vacate the court's September 16, 1986 Opinion and Order and its September 18, 1986 Judgment in this case.

8. In the event that the District Court declines to vacate its order, opinion and judgment described in paragraph 7, or fails to do so before the deadline (including any extension) for the Secretary to file a notice of appeal, the Secretary will notice an appeal, and Greenville will join with the Secretary in a motion to the United States Court of Appeals for the Fourth Circuit to dismiss the Secretary's appeal as moot, with instructions to vacate the District Court decision.

9. If the District Court grants the motion to vacate the order, opinion and judgment, the Secretary agrees not to appeal the district court's order. The Secretary further agrees that after the order, opinion and judgment have been vacated by either the District Court or the Court of Appeals, the Secretary will instruct Blue Cross to adjust Greenville's hospital-specific rate for the first PPS transition year in accordance with the methodology set forth in the Administrator's letter described in paragraph 4, above. Blue Cross will then be instructed to make payment to Greenville based on the revised rate, with interest in accordance with 42 U.S.C. § 1395oo(f)

(2) and implementing regulations, where the 180 day period is deemed to begin with the date of the intermediary's original notice to Greenville of its PPS rate. This payment will be made within thirty days of entry of an order vacating the district court's order, opinion and judgment.

10. This agreement is entirely contingent on the vacation of the September 16, 1986 opinion and order and the September 18, 1986 judgment, of the United States District Court for the District of South Carolina, Greenville Division, in Civil Action No. 6:85-337-3. If both the District Court and the Court of Appeals decline to vacate this order, opinion and judgment, or if any court at any time strikes either this Agreement or any portion thereof, this entire Agreement shall be null and void.

12. The parties agree not to disclose the terms of this Stipulation and Agreement or to describe or characterize the Agreement in any manner whatsoever, except as provided in this paragraph, and to cause their employees, agents, assigns, and attorneys to keep confidential each and every term of this Agreement. Nothing in this confidentiality provision shall be construed to deny to either party the right to bring or prosecute fully an action for breach of this Stipulation. The parties may state that the litigation has been settled pursuant to an agreement the terms of which are confidential.

13. The parties agree that this Stipulation and Agreement is solely for the purpose of resolving this action, and that its provisions are not intended to be of any force, effect, or precedential value beyond the confines of the instant dispute. The parties further agree that nothing contained herein shall be deemed to be a concession or admission by the defendant with respect to any allegations by Greenville, and may not be relied upon or introduced in this or any other judicial or administrative proceedings, by any of the parties, or by counsel for any of the parties, for any purpose, except as may be neces-

sary for enforcing any provisions of this agreement. In particular, the settlement shall not bind either party in any other proceeding not arising out of the particular facts described in the Complaint.

14. The parties agree that neither party is a "prevailing party" within the meaning of 28 U.S.C. § 2412. As between plaintiff and defendant, each party shall bear its own costs and attorney fees.

15. The parties agree that this Stipulation and Agreement shall resolve all matters upon which the Complaint in this action was brought; and that there remains no other issue of fact or law requiring further proceedings before the Court.

FOR GREENVILLE HOSPITAL SYSTEM

HAYNSWORTH, MARION, McKAY & GUERARD

/s/ James B. Pressly, Jr.
JAMES B. PRESSLY, JR.
2 Shelter Centre, 11th Floor
75 Beattie Place
Greenville, SC 29601

Date: 12/16/86

OBER, KALER, GRIMES & SHRIVER

/s/ Carel T. Hedlund
LEONARD C. HOMER
CAREL T. HEDLUND
1600 Maryland National Bank Building
Baltimore, MD 21202

Date: 12/15/86

FOR THE SECRETARY OF HEALTH AND HUMAN SERVICES

VINTON D. LIDE
UNITED STATES ATTORNEY

/s/ James D. McCoy, III
JAMES D. McCOY, III
Assistant U.S. Attorney
Federal Building
300 E. Washington Street
Greenville, SC 29603

Date: 12/16/86

/s/ Vicki L. Schulkin
VICKI L. SCHULKIN
Attorney
Office of the General Counsel
Department of Health and Human Services
Room 5440
330 Independence Avenue, SW
Washington, DC 20201

Date: 12/12/86

APPENDIX M

STATUTORY PROVISIONS

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§ 1395ww. Payments to hospitals for inpatient hospital services

(a) Determination of costs for inpatient hospital services; limitations; exemptions; "operating costs of inpatient hospital services" defined

(1)(A)(i) The Secretary, in determining the amount of the payments that may be made under this subchapter with respect to operating costs of inpatient hospital services (as defined in paragraph (4)) shall not recognize as reasonable (in the efficient delivery of health services) costs for the provision of such services by a hospital for a cost reporting period to the extent such costs exceed the applicable percentage (as determined under clause (ii)) of the average of such costs for all hospitals in the same grouping as such hospital for comparable time periods.

(ii) For purposes of clause (i), the applicable percentage for hospital cost reporting periods beginning—

(I) on or after October 1, 1982, and before October 1, 1983, is 120 percent;

(II) on or after October 1, 1983, and before October 1, 1984, is 115 percent; and

(III) on or after October 1, 1984, is 110 percent.

(B)(i) For purposes of subparagraph (A) the Secretary shall establish case mix indexes for all short-term hospitals, and shall set limits for each hospital based upon the general mix of types of medical cases with respect to which such hospital provides services for which payment may be made under this subchapter.

(ii) The Secretary shall set such limits for a cost reporting period of a hospital—

(I) by updating available data for a previous period to the immediate preceding cost reporting period by the estimated average rate of change of hospital costs industry-wide, and

(II) by projecting for the cost reporting period by the applicable percentage increase (as defined in subsection (b)(3)(B) of this section).

C) The limitation established under subparagraph (A) for any hospital shall in no event be lower than the allowable operating costs of inpatient hospital services (as defined in paragraph (4)) recognized under this subchapter for such hospital for such hospital's last cost reporting period prior to the hospital's first cost reporting period for which this section is in effect.

(D) Subparagraph (A) shall not apply to cost reporting periods beginning on or after October 1, 1983.

(2) The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established under paragraph (1)(A) as he deems appropriate, including those which he deems necessary to take into account—

(A) the special needs of sole community hospitals, of new hospitals, of risk based health maintenance organizations, and of hospitals which provide atypical services or essential community services, and to take into account extraordinary circumstances beyond the hospital's control, medical and paramedical education costs, significantly fluctuating population in the service area of the hospital, and unusual labor costs,

(B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this subchapter, and

(C) a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services.

(3) The limitation established under paragraph (1)(A) shall not apply with respect to any hospital which—

(A) is located outside of a standard metropolitan statistical area, and

(B)(i) has less than 50 beds, and

(ii) was in operation and had less than 50 beds on September 3, 1982.

(4) For purposes of this section, the term "operating costs of inpatient hospital services" includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services as such costs are determined on an average per admission or per discharge basis (as determined by the Secretary). Such term does not include costs of approved educational activities, a return on equity capital, or, other capital-related costs (as defined by the Secretary for periods before October 1, 1987).

(b) Computation of payment; definitions; exemptions; adjustments

(1) Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title, if the operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) of a hospital (other than a subsection (d) hospital, as defined in subsection (d)(1)(B) of this section) for a cost reporting period subject to this paragraph—

(A)are less than or equal to the target amount (as defined in paragraph (3)) for that hospital for that period, the amount of the payment with respect to

such operating costs payable under part A of this subchapter on a per discharge or per admission basis (as the case may be) shall be equal to the amount of such operating costs, plus—

(i) 50 percent of the amount by which the target amount exceeds the amount of the operating costs, or

(ii) 5 percent of the target amount,

whichever is less; or

(B) are greater than the target amount, the amount of the payment with respect to such operating costs payable under Part A of this subchapter on a per discharge or per admission basis (as the case may be) shall be equal to (i) the target amount, plus (ii) in the case of cost reporting periods beginning on or after October 1, 1991, an additional amount equal to 50 percent of the amount by which the operating costs exceed the target amount (except that such additional amount may not exceed 10 percent of the target amount) after any exceptions or adjustments are made to such target amount for the cost reporting period;

except that in no case may the amount payable under this subchapter (other than on the basis of a DRG prospective payment rate determined under subsection (d) of this section) with respect to operating costs of inpatient hospital services exceed the maximum amount payable with respect to such costs pursuant to subsection (a) of this section.

(2) Repealed. Pub.L. 98-21, Title VI, § 601(b)(4), Apr. 20, 1983, 97 Stat. 150

(3)(A) Except as provided in subparagraphs (C), (D), and (E), for purposes of this subsection, the term "target amount" means, with respect to a hospital for a particular 12-month cost reporting period—

(i) in the case of the first such reporting period for which this subsection is in effect, the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) recognized under this subchapter for such hospital for the preceding 12-month cost reporting period, and

(ii) in the case of a later reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase under subparagraph (B) for that particular cost reporting period.

* * * *

(4)(A) The Secretary shall provide for an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured). The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services and including those which he deems necessary to take into account a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services. The Secretary shall announce a decision on any request for an exemption, exception, or adjustment under this paragraph not later than 180 days after receiving a completed application from the intermediary for such exemption, exception or adjustment, and shall include in such decision a detailed ex-

planation of the grounds on which such request was approved or denied.

(B) In determining under subparagraph (A) whether to assign a new base period which is more representative of the reasonable and necessary cost to a hospital of providing inpatient services, the Secretary shall take into consideration—

(i) changes in applicable technologies and medical practices, or differences in the severity of illness among patients, that increase the hospital's costs;

(ii) whether increases in wages and wage-related costs for hospitals located in the geographic area in which the hospital is located exceed the average of the increases in such costs paid by hospitals in the United States; and

(iii) such other factors as the Secretary considers appropriate in determining increases in the hospital's costs of providing inpatient services.

(C) Paragraph (1) shall not apply to payment of hospitals which is otherwise determined under paragraph (3) of section 1395f(b) of this title.

* * * *

(d) Inpatient hospital service payments on basis of prospective rates; Medicare Geographic Classification Review Board

(1)(A) Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) of a subsection (d) hospital (as defined in subparagraph (B)) for inpatient hospital discharges in a cost reporting period or in a fiscal year—

(i) beginning on or after October 1, 1983, and before October 1, 1984, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in sub-

section (b)(3)(A) of this section, but determined without the application of subsection (a) of this section), and

(II) the DRG percentage (as defined in subparagraph (C)) of the regional adjusted DRG prospective payment rate determined under paragraph (2) for such discharges;

(ii) beginning on or after October 1, 1984, and before October 1, 1987, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A) of this section, but determined without the application of subsection (a) of this section), and

(II) the DRG percentage (as defined in subparagraph (C)) of the applicable combined adjusted DRG prospective payment rate determined under subparagraph (D) for such discharges; or

(iii) beginning on or after April 1, 1988, and ending on September 30, 1993, the sum of (I) 85 percent of the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, and (II) 15 percent of the regional adjusted DRG prospective payment rate determined under such paragraph.

(B) As used in this section, the term "subsection (d) hospital" means a hospital located in one of the fifty States or the District of Columbia other than—

(i) a psychiatric hospital (as defined in section 1395x(f) of this title),

(ii) a rehabilitation hospital (as defined by the Secretary),

(iii) a hospital whose inpatients are predominantly individuals under 18 years of age,

(iv) a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days, or

(v) a hospital that the Secretary has classified, at any time on or before December 31, 1990, (or, in the case of a hospital that, as of December 19, 1989, is located in a State operating a demonstration project under section 1395f(b) of this title, on or before December 31, 1991) for purposes of applying exceptions and adjustments to payment amounts under this subsection, as a hospital involved extensively in treatment for or research on cancer;

and, in accordance with regulations of the Secretary, does not include a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital (as defined by the Secretary).

(C) For purposes of this subsection, for cost reporting periods beginning—

(i) on or after October 1, 1983, and before October 1, 1984, the "target percentage" is 75 percent and the "DRG percentage" is 25 percent;

(ii) on or after October 1, 1984, and before October 1, 1985, the "target percentage" is 50 percent and the "DRG percentage" is 50 percent;

(iii) on or after October 1, 1985, and before October 1, 1986, the "target percentage" is 45 percent and the "DRG percentage" is 55 percent; and

(iv) on or after October 1, 1986, and before October 1, 1987, the "target percentage" is 25 percent and the "DRG percentage" is 75 percent.

(D) For purposes of subparagraph (A)(ii)(II), the "applicable combined adjusted DRG prospective payment rate" for discharges occurring—

(i) on or after October 1, 1984, and before October 1, 1986, is a combined rate consisting of 25 percent of the national adjusted DRG prospective payment rate, and 75 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges; and

(ii) on or after October 1, 1986, and before October 1, 1987, is a combined rate consisting of 50 percent of the national adjusted DRG prospective payment rate, and 50 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges.

(5)(A)(i) The Secretary shall provide for an additional payment for a subsection (d) hospital for any discharge in a diagnosis-related group, the length of stay of which exceeds the mean length of stay for discharges within that group by a fixed number of days, or exceeds such mean length of stay by some fixed number of standard deviations, whichever is the fewer number of days.

(ii) For cases which are not included in clause (i), a subsection (d) hospital may request additional payments in any case where charges, adjusted to cost, exceed a fixed multiple of the applicable DRG perospective payment rate, or exceed such other fixed dollar amount, whichever is greater.

(iii) The amount of such additional payment under clauses (i) and (ii) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable under clause (i) or (ii).

(iv) The total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

* * * *

(C)(i) The Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection (other than under paragraph (9)) as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 275 or more beds located in rural areas). . . .

* * * *

(I) The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.

APPENDIX N

REGULATIONS

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42 C.F.R. § 412.2

§ 412.2 Basis of payment.

* * * *

(b) *Payment in full.* (1) The prospective payment amount paid for inpatient hospital services is the total Medicare payment for the inpatient operating costs (as described in paragraph (c) of this section) incurred in furnishing services covered by the Medicare program.

(2) The full prospective payment amount, as determined under Subpart D, E, or G of this part, is made for each stay during which there is at least one Medicare payable day of care. Payable days of care, for purposes of this paragraph (b)(2), include the following:

(i) Waiver of liability days payable under § 405.330 of this chapter.

(ii) Guarantee of payment days, as authorized under § 409.68 of this chapter, for inpatient hospital services furnished to an individual whom the hospital has reason to believe is entitled to Medicare benefits at the time of admission.

42 C.F.R. § 412.70

§ 412.70 General description.

(a) *Basic rules.* (1) During the initial four-year transition period, payments to all hospitals paid under the prospective payment system are based on a combination of the Federal prospective payment rates, as determined under Subpart D of this part, and hospital-specific rates determined under this subpart.

(2) For the first two years of the transition period, both portions of the payment rates are also adjusted to ensure budget neutrality.

(3) At the end of the transition period (that is, for cost reporting periods beginning on or after October 1, 1987), payments are based on the national prospective payment rates determined under subpart D of this part, except for payments that may be made under the special treatment provisions of Subpart G of this part.

(b) *Payment amounts based on the hospital-specific portion and the Federal portion.* For discharges occurring in cost reporting periods beginning on or after October 1, 1983 and before October 1, 1987, the Medicare transition payment rate for a particular covered discharge equals a blend of the applicable portion of the hospital-specific rate, as determined under § 412.73, plus the applicable portions of the Federal national and regional prospective payment rates, as described in paragraph (c) of this section, and summarized in the Table. Payments to new hospitals are based on the Federal national and regional prospective payments rates, as described in paragraph (d) of this section.

(c) *Amount of blended portions.*[1] The blends of hospital-specific and Federal portions are as follows:

(1) For cost reporting periods beginning on or after October 1, 1983 and before October 1, 1984, the blend is—

(i) 75 percent of the hospital-specific rate; and

(ii) 25 percent of the appropriate Federal prospective payment rate.

(2) For cost reporting periods beginning on or after October 1, 1984 and before October 1, 1985, the blend is—

(i) 50 percent of the hospital-specific rate; and

(ii) 50 percent of the appropriate Federal prospective payment rate.

(3) For cost reporting periods beginning on or after October 1, 1985 and before October 1, 1986, the blend is as follows:

(i) For the first seven months of the cost reporting period, the blend is—

(A) 50 percent of the hospital-specific rate; and

(B) 50 percent of the appropriate Federal prospective payment rate.

(ii) For the remaining five months of the cost reporting period, the blend is—

(A) 45 percent of the hospital-specific rate; and

(B) 55 percent of the appropriate Federal prospective payment rate.

(4) For cost reporting periods beginning on or after October 1, 1986 and before October 1, 1987, the blend is—

(i) 25 percent of the hospital-specific rate; and

(ii) 75 percent of the appropriate Federal prospective payment rate.

(5) The appropriate Federal prospective payment rate is a combined regional and national rate and changes with the Federal fiscal year. For Federal fiscal year 1984, which begins October 1, 1983, the Federal prospective payment rate is 100 percent regional. For Federal fiscal years 1985 and 1986, which begin October 1, 1984 and October 1, 1985, respectively, the combined rate is 75 percent regional and 25 percent national. For Federal fiscal year 1987, which begins October 1, 1986, the combined rate is 50 percent regional and 50 percent national. Effective with Federal fiscal year 1988, which begins October 1, 1987, the Federal prospective payment rate is 100 percent national except as provided in paragraph (c)(6) of this section.

(6) For discharges occurring on or after April 1, 1988 and before October 1, 1990, payments to a hospital are based on the greater of the national average standardized amount or the sum of 85 percent of the national average standardized amount and 15 percent of the average standardized amount for the region in which the hospital is located.

TABLE—SUMMARY OF HOSPITAL-SPECIFIC AND FEDERAL PORTION PERCENTAGES FOR DETERMINING TRANSITION PAYMENT RATES

Cost reporting period beginning on or after	Hospital-specific portion percentage	Federal portion percentage *
October 1, 1983	75	25
October 1, 1984	50	50
October 1, 1985—		
The first seven months of the cost reporting period	50	50
The remaining five months of the cost reporting period	45	55
October 1, 1986	25	75
Otcober 1, 1987	0	100

* NOTE: The Federal portion percentages are applied to the combined national or regional prospective payment rates, as appropriate, as determined under Subpart D of this part for the Federal fiscal year in which discharge occurs.

(d) *Blended portions for new hospitals.* The prospective payment rates for new hospitals are a blend of the Federal regional and national rates as follows:

(1) For discharges occurring on or after October 1, 1983, and before October 1, 1984, the prospective payment rate equals the appropriate Federal regional rate.

(2) For discharges occurring on or after October 1, 1984 and before October 1, 1986, the prospective payment rate is a blend of—

(i) 75 percent of the appropriate Federal regional prospective payment rate; and

(ii) 25 percent of the appropriate Federal national rate.

(3) For discharges occurring on or after October 1, 1986 and before October 1, 1987, the prospective payment rate is a blend of—

(i) 50 percent of the appropriate Federal regional prospective payment rate; and

(ii) 50 percent of the appropriate Federal national prospective payment rate.

(4) For discharges occurring on or after October 1, 1987, the prospective payment rate equals the appropriate Federal national rate except as provided in paragraph (d)(5) of this section.

(5) For discharges occurring on or after April 1, 1988 and before October 1, 1990, payments to a hospital are based on the greater of the national average standardized amount or the sum of 85 percent of the national average standardized amount and 15 percent of the average standardized amount for the region in which the hospital is located.

[51 FR 16786, May 6, 1986, as amended at 53 FR 38528, Sept. 30, 1988]

42 C.F.R. § 412.71

§ 412.71 Determination of base-year costs.

(a) *Base-year costs.* (1) For each hospital, the intermediary will estimate the hospital's Medicare Part A allowable inpatient operating costs, as described in § 412.2(c), for the 12-month or longer cost reporting period ending on or after September 30, 1982 and before September 30, 1983.

(2) If the hospital's last cost reporting period ending before September 30, 1983 is for less than 12 months, the base period wil be the hospital's most recent 12-month or longer cost reporting period ending before such short reporting period, with an appropriate adjustment for inflation. (The rules applicable to new hospitals are set forth in § 412.74.)

(b) *Modifications to base-year costs.* Prior to determining the hospital-specific rate, the intermediary will adjust the hospital's estimated base-year inpatient operating costs, as necessary, to include malpractice insurance costs as described in § 413.55 of this chapter, and exclude the following:

(1) Nursing differential costs as described in § 405.430 [1] of this chapter.

(2) Medical education costs as described in § 413.85 of this chapter.

(3) Capital-related costs as described in § 413.130 of this chapter.

(4) Kidney acquisition costs incurred by hospitals approved as renal transplantation centers as described in § 412.100. Kidney acquisition costs in the base year will be determined by multiplying the hospital's average kidney acquisition cost per kidney times the number of kidney transplants covered by Medicare Part A during the base period.

(5) Higher costs that were incurred for purposes of increasing base-year costs.

(6) One-time nonrecurring higher costs or revenue offsets that have the effect of distorting base-year costs as an appropriate basis for computing the hospital-specific rate.

(7) Higher costs that result from changes in hospital accounting principles initiated in the base year.

(8) For cost reporting periods beginning on or after October 1, 1984 through any part of a cost reporting period occurring before January 1, 1989, the cost of qualified nonphysician anesthetists' services as described in § 412.113(c).

(c) *Hospital's request for adjustment of base-year costs.* (1) Before the date it becomes subject to the prospective payment system, a hospital may request the intermediary to further adjust its estimated base-period costs to take into account the following:

(i) Services paid for under Medicare Part B during the hospital's base year that will be paid for under prospective payments. The base-year costs may be increased to include estimated payments for certain services previously billed as physicians' services before the effective date of § 405.550(b) of this chapter, and estimated payments for nonphysicians' services that were not furnished either directly or under arrangements before October 1, 1983 (the effective date of § 405.310(m) of this chapter), but may not include the costs of anesthetists' services for which a physician employer continues to bill under § 405.553(b)(4) of this chapter.

(ii) The payment of FICA taxes during cost reporting periods subject to the prospective payment system, if the hospital had not paid such taxes for all its employees during its base period and will be required to participate effective January 1, 1984.

(2) If a hospital requests that its base-period costs be adjusted under paragraph (c)(1) of this section, it must timely provide the intermediary with sufficient documentation to justify the adjustment, and adequate data to compute the adjusted costs. The intermediary will decide whether to use part or all of the data on the basis of audit, survey and other information available.

(d) *Intermediary's determination.* The intermediary will use the best data available at the time in estimating

each hospital's base-year costs and the modifications to those costs authorized by paragraphs (b) and (c) of this section. The intermediary's estimate of base-year costs and modifications thereto is final and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983, except as provided in § 412.72.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 52 FR 33057, Sept. 1, 1987]

42 C.F.R. § 412.72

§ 412.72 Modification of base-year costs.

(a) *Bases for modification of base-year costs.* Base-year costs as determined under § 412.71(d) may be modified under the following circumstances:

(1) *Inadvertent omissions.* (i) A hospital that becomes subject to the prospective payment system beginning on or after October 1, 1983 and before November 16, 1983 has until November 15, 1983 to request its intermediary to reestimate its base-period costs to take into account inadvertent omissions in its previous submissions to the intermediary related to changes made by the prospective payment legislation for purposes of estimating the base-period costs.

(ii) The intermediary may also initiate changes to the estimation—

(A) For any reason before the date the hospital becomes subject to prospective payment; and

B) Before November 16, 1983, for corrections to take into account inadvertent omissions in the hospital's previous submissions related to changes made by the prospective payment legislation for purposes of estimating the base-period costs.

(iii) Such omissions pertain to adjustments to exclude capital-related costs and the direct medical education costs of approved educational activities and to adjustments specified in § 412.71(c).

(iv) The intermediary must notify the provider of any change to the hospital-specific amount as a result of the provider's request within 30 days of receipt of the additional data.

(v) Any change to base-period costs made under this paragraph (a)(1) will be made effective retroactively, beginning with the first day of the affected hospital's fiscal year.

(2) *Correction of mathematical errors of calculations.* (i) The hospital must report mathematical errors of calculations to the intermediary within 90 days of the intermediary's notification to the hospital of the hospital's payment rates.

(ii) The intermediary may also identify such errors and initiate their correction during this perod.

(iii) The intermediary will either make an appropriate adjustment or notify the hospital that no adjustment is warranted within 30 days of receipt of the hospital's report of an error.

(iv) Corrections of errors of calculation will be effective with the first day of the hospital's first cost reporting period subject to the prospective payment system.

(3) *Recognition of additional costs.* (1) The intermediary may adjust base-period costs to take into account additional costs recognized as allowable costs for the hospital's base year as the result of any of the following:

(A) A reopening and revision of the hospital's base-year notice of amount of program reimbursement under §§ 405.1885 through 405.1889 of this chapter.

(B) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under § 405.1821 or § 405.1853 of this chapter that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement.

(C) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of HCFA under § 405.1875 of this chapter that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement.

(D) An administrative or judicial review decision under §§ 405.1831, 405.1871, or 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement.

(ii) The intermediary will recalculate the hospital's base-year costs, incorporating the additional costs recognized as allowable for the hospital's base year. Adjustments to base-year costs to take into account these additional costs—

(A) Will be effective with the first day of the hospital's first cost reporting period beginning on or after the date of the revision, order or finding, or review decision; and

(B) Will not be used to recalculate the hospital-specific portion as determined for fiscal years beginning before the date of the revision, order or finding, or review decision.

(4) *Successful appeal.* The intermediary may modify base-year costs to take into account a successful appeal relating to modifications to base-year costs that were made under § 412.71(b). If a hospital successfully contests a modification to base-year costs—

(i) The intermediary will recalculate the hospital's base-year costs to reflect the modification determined appropriate as a result of the appeal; and

(ii) Such adjustments will be effective retroactively to the time of the intermediary's initial estimation of base-year costs.

(5) *Unlawfully claimed costs.* The intermediary may modify base-year costs to exclude costs that were unlawfully claimed as determined as a result of criminal conviction, imposition of a civil judgment under the False Claims Act (31 U.S.C. 3729-3731), or a proceeding for exclusion from the Medicare program. In addition to adjusting base-year costs, HCFA will recover both the excess costs reimbursed for the base period and the additional amounts paid due to the inappropriate increase of the hospital-specific portion of the hospital's transition payment rates. The amount to be recovered will be computed on the basis of the final resolution of the amount of the inappropriate base-year costs.

(b) *Right to administrative and judicial review.* (1) An intermediary's estimation of a hospital's base-year costs, and modifications, made for purposes of determining the hospital-specific rate, are subject to administrative and judicial review. Review will be available to a hospital upon receipt of its notice of amount of program reimbursement following the close of its cost reporting period, but only with respect to whether the intermediary followed the provisions of §§ 412.71 and 412.72. (Sections 405.1803 and 405.1807 of this chapter set forth the rules for intermediary determinations and notice of amount of program reimbursement and the effect of those determinations.)

(2) In any administrative or judicial review of whether the intermediary used the best data available at the time, as required by § 412.71(d), an intermediary's estimation will be revised on the basis of this review only

if the estimation was unreasonable and clearly erroneous in light of the data available at the time the estimation was made.

(3) Specifically excluded from administrative or judicial review are any issues based on data, information, or arguments not presented to the intermediary at the time of the estimation.

APPENDIX O

H.R. Conf. Rep. No. 47, 98th Cong., 1st Sess. 182, *reprinted in* 1983 U.S. Code Cong. & Admin. News 404, 471-72

HOUSE BILL

UNDER THE HOUSE BILL, FOR THE FIRST 2 REPORTING PERIODS, THE CALCULATION OF THAT PORTION OF A HOSPITAL'S PAYMENT WHICH IS COST-BASED WOULD BE THE LESSER OF THE HOSPITAL'S PAYMENT UNDER THE RATE OF INCREASE LIMITS, WITHOUT THE PENALTIES AND BONUSES OF PRESENT LAW, OR THE SECTION 223 LIMITS WITHOUT REGARD TO ANY EXEMPTIONS, EXCEPTIONS OR ADJUSTMENTS THERETO. FOR THE THIRD REPORTING PERIOD, THE CALCULATION OF THE COST-BASED PORTION WOULD BE THE HOSPITAL'S PAYMENT UNDER THE RATE OF INCREASE LIMIT ONLY.

SENATE AMENDMENT

SAME PROVISION, EXCEPT THE SECTION 223 LIMITS WOULD NOT APPLY.

CONFERENCE AGREEMENT

THE CONFERENCE AGREEMENT FOLLOWS THE SENATE AMENDMENT. THE MANAGERS NOTE THAT DURING THE PHASE-IN PERIOD, SOME PORTION OF THE PROSPECTIVE PAYMENT RATE WILL BE RELATED TO EACH HOSPITAL'S OWN EXPERIENCE IN A BASE COST REPORTING YEAR. THE MANAGERS RECOGNIZE THAT, IN SOME CASES, THE SECRETARY WILL HAVE TO USE ESTIMATES TO ADJUST SOME PORTIONS OF THE HOSPITAL'S BASE YEAR EXPERIENCE TO MAKE IT COMPARABLE TO INPATIENT OPERAT-

ING COSTS THAT WILL BE PAID UNDER THE PROSPECTIVE SYSTEM—E.G., FICA TAXES THAT WOULD HAVE BEEN PAID IF THE HOSPITAL HAD BEEN IN THE SOCIAL SECURITY SYSTEM OR THE ADJUSTMENT NEEDED TO EXCLUDE THE NURSING DIFFERENTIAL WHICH IS NO LONGER PAYABLE. SINCE THE HOSPITAL'S SPECIFIC PORTION OF THE RATE MUST BE DETERMINED IN ADVANCE OF THE HOSPITAL'S FIRST FISCAL YEAR UNDER THE SYSTEM, THE MANAGERS EXPECT THE SECRETARY WILL USE THE BEST DATA AVAILABLE AT THAT TIME TO DETERMINE OPERATING COSTS FOR PURPOSES OF THE PHASE-IN.

H.Rep. No. 25, 98th Cong., 1st Sess. 136, *reprinted in* 1983 U.S. Code Cong. & Admin. News 219, 355 ("H.R. 98-25")

THE PORTION OF A HOSPITAL'S PAYMENT DETERMINED ON ITS OWN COST BASE WOULD BE CALCULATED AS THOUGH THE HOSPITAL'S TARGET AMOUNT UNDER THE 1982 TEFRA LEGISLATION WERE ITS PAYMENT AMOUNT (THAT IS, WITHOUT APPLICATION OF THE PROVISIONS UNDER WHICH A HOSPITAL RETAINS ONLY A PORTION OF ITS COST-PER-CASE SAVINGS BELOW THE TARGET AMOUNT AND MEDICARE PAYS ANY PORTION OF THE HOSPITAL'S COST PER CASE IN EXCESS OF THE TARGET AMOUNT, AND WITHOUT REGARD TO THE EXCEPTIONS, EXEMPTIONS AND ADJUSTMENTS WHICH MAY HAVE BEEN AUTHORIZED UNDER TEFRA FOR THAT YEAR). THE PAYMENT AMOUNT, LIKE THE TARGET AMOUNT UNDER PRESENT LAW, IS PROJECTED FROM THE HOSPITAL'S COST BASE. BECAUSE THE PAYMENT CAN BE DETERMINED WITHOUT REFERENCE TO THE HOSPITAL'S COSTS IN THE CURRENT YEAR, IT CAN BE PROSPECTIVELY DETERMINED.

S.Rep. No. 23, 98th Cong., 1st Sess. 53, *reprinted in* 1983 U.S. Code Cong. & Admin. News 143, 193

COMMITTEE AMENDMENT

THE PROSPECTIVE PAYMENT SYSTEM WOULD BE EFFECTIVE FOR INDIVIDUAL HOSPITAL ACCOUNTING YEARS BEGINNING ON OR AFTER OCTOBER 1, 1983, AND WOULD BE PHASED-IN OVER A THREE YEAR PERIOD. IN YEAR ONE, 25 PERCENT OF THE PAYMENT WOULD BE BASED ON A COMBINATION OF NATIONAL AND REGIONAL DRG RATES (25 PERCENT NATIONAL, 75 PERCENT REGIONAL); 75 PERCENT WOULD BE BASED ON EACH HOSPITAL'S OWN COST-BASED EXPERIENCE. IN YEAR TWO, 50 PERCENT OF THE PAYMENT WOULD BE BASED ON A COMBINATION OF NATIONAL AND REGIONAL DRG RATES (50 PERCENT EACH); 50 PERCENT WOULD BE BASED ON EACH HOSPITAL'S COST EXPERIENCE. IN YEAR THREE, 75 PERCENT OF THE PAYMENT WOULD BE BASED ON A COMBINATION OF DRG RATES (75 PERCENT NATIONAL, 25 PERCENT REGIONAL); 25 PERCENT WOULD BE BASED ON EACH HOSPITAL'S COST EXPERIENCE. IN YEAR FOUR, THE ENTIRE PAYMENT WOULD BE BASED ON NATIONAL DRG RATES, CALCULATED SEPARATELY FOR HOSPITALS LOCATED IN URBAN AND RURAL AREAS. THE PHASE-IN OF NATIONAL DRG RATES OVER THE THREE-YEAR PERIOD IS DESIGNED TO MINIMIZE DISRUPTION THAT MIGHT OTHERWISE OCCUR BECAUSE OF SUDDEN CHANGES IN REIMBURSEMENT LEVELS.

THE SECTION 223 LIMITS PROVIDED UNDER CURRENT LAW WOULD BE REPEALED EFFECTIVE FOR HOSPITAL COST REPORTING PERIODS

BEGINNING ON OR AFTER OCTOBER 1, 1983. HOWEVER, HOSPITALS OR UNITS OF HOSPITALS NOT INCLUDED IN THE PROSPECTIVE PAYMENT SYSTEM WOULD BE SUBJECT TO THE SAME RATE OF INCREASE LIMITATION AS CONTAINED IN TEFRA, INCLUDING THE PENALTIES AND BONUSES. THE RATE OF INCREASE USED TO UP-DATE THESE LIMITS WOULD BE THAT WHICH IS CURRENTLY CONTAINED IN TEFRA, MARKET BASKET PLUS ONE PERCENTAGE POINT.

98th Congress
1st Session

H.R. 1900

[Report No. 98-25, Part I]

To assure the solvency of the Social Security Trust Funds, to reform the medicare reimbursement of hospitals, to extend the Federal supplemental compensation program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 3, 1983

Mr. ROSTENKOWSKI (for himself, Mr. PICKLE, and Mr. CONABLE) introduced the following bill; which was referred to the Committee on Ways and Means

MARCH 4, 1983

Reported and referred to the Committee on Appropriations for a period not to exceed 15 legislative days with instructions to report back to the House as provided in section 401(b) of Public Law 93-344

A BILL

To assure the solvency of the Social Security Trust Funds, to reform the medicare reimbursement of hospitals, to extend the Federal supplemental compensation program, and for other purposes.

* * * *

(d) Subsection (d) of such section, as added by section 110 of the Tax Equity and Fiscal Responsibility Act of 1982, is amended—

(1) by striking out "section 1814(b)" in paragraph (2)(A) and inserting in lieu thereof "subsection (b)", and

(2) by redesignating the subsection as subsection (j) and transferring and inserting such subsection at the end of section 1814 of the Social Security Act under the following heading:

"Elimination of Lesser-of-Cost or-Charges Provision".

(e) Such section 1886 is further amended by adding at the end the following new subsections:

"(d)(1)(A) Notwithstanding section 1814(b) but subject to the provisions of section 1813, the amount of the payment with respect to the operating costs of inpatient hospital services (as defined in subsection (a)(4) of a subsection (d) hospital (as defined in subparagraph (B)) for inpatient hospital discharges in a cost reporting period or in a fiscal year—

"(i) beginning on or after October 1, 1983, and before October 1, 1986, is equal to the sum of—

"(I) the target percentage (as defined in subparagraph (C)) of the lesser of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A)), or the limitation established under subsection (a) (determined without regard to paragraph (2) thereof) for the period, and

"(II) the DRG percentage (as defined at subparagraph (C)) of the adjusted DRG prospective payment rate determined under paragraph (2) or (3) for such discharges; or

"(ii) beginning on or after October 1, 1986, is equal to the adjusted DRG prospective payment rate determined under paragraph (3) for such discharges.

* * * *

APPENDIX P

PROPOSED RULES

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 412

[BERC-326-P]

Medicare Program; Clarification of Policy on Adjusting the Hospital-Specific Portion of the Prospective Payment Rate

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would clarify Medicare's policy regarding changes to the hospital-specific portion of the prospective payment rate for inpatient hospital services. We would clarify that exemptions, exceptions, and adjustments to base year costs permitted under the Medicare cost limits and rate-of-increase ceiling authority will affect the hospital-specific portion of the prospective payment rate.

DATE: To be considered, comments must be mailed or delivered to the appropriate address, as provided below, and must be received by 5:00 p.m. on April 19, 1986.

ADDRESS: Mail comments to the following address: Health Care Financing Administration, Department of

Health and Human Services, Attention: BERC-326-P.P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your comments to one of the following addresses:

Room 309-G, Hubert H. Humphrey Building,
200 Independence Ave., S.W.,
Washington, D.C.;

or

Room 132, East High Rise Building,
6325 Security Boulevard,
Baltimore, Maryland

In commenting, please refer to file code BERC-326-P.

Comments will be available for public inspection as they are received, beginning approximately three weeks after publication of this document in Room 309—G of the Department's offices at 200 Independence Ave., SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (phone: 202-245-7890).

FOR FURTHER INFORMATION CONTACT:
Edward Rees (301) 597-6403.

SUPPLEMENTARY INFORMATION:

I. General Background

Under section 1886(d) of the Social Security Act (the Act), enacted by the Social Security Amendments of 1983 (Pub. L. 98-21) on April 20, 1983, a prospective payment system for Medicare payment of inpatient hospital services was established effective with hospital cost reporting periods beginning on or after October 1, 1983. Under this system, Medicare payment is made at a predetermined, specific rate for each hospital discharge. All discharges are classified according to a list of diagnosis-related groups

(DRGs). This list currently contains 471 specific categories.

In order to implement the prospective payment system for inpatient hospital services as required by section 1886(d) of the Act, we published the following documents in the Federal Register.

• On September 1, 1983, we published an interim final rule with comment period (48 FR 39752), effective for hospital cost reporting periods beginning on or after October 1, 1983. Technical corrections were issued on October 19, 1983 (48 FR 48467).

• On January 3, 1984, we published a final rule (49 FR 234) that made changes to the regulations as the result of our consideration of the public comments that were received in response to the interim final rule. Technical corrections for this document were issued on June 1, 1984 (49 FR 23010).

• In order to update the prospective payment rates for Federal fiscal year 1985, we published a proposed rule on July 3, 1984 (49 FR 27422) and a final rule on August 31, 1984 (49 FR 34728), for which technical corrections were issued on October 15, 1984 (49 FR 40167).

• On March 29, 1985, we published a final rule (50 FR 12740) redesignating the prospective payment regulations, originally set forth in 42 CFR Part 405 (§§ 405.470 through 405.477), to a new 42 CFR Part 412 (§§ 412.1 through 412.125). That final rule was a technical document, the purpose of which was to make the prospective payment regulations easier to use.

• In order to update the prospective payment rates for Federal fiscal year 1986, we published a proposed rule June 10, 1985 (50 FR 24366) and a final rule on September 3, 1985 (50 FR 35646), for which technical corrections were issued on October 28, 1985 (50 FR 43570). However, section 5 of Pub. L. 99-107, as amended by

section 2 of Pub. L. 99-201, postponed implementation of the revised Medicare payment rules through March 14, 1986. (See the February 3, 1986 Federal Register notice (51 FR 4166).)

As a result of our experience with the prospective payment system to date, we are now proposing to clarify 42 CFR 412.72 (formerly § 405.474(b)), which describes modifications to base year costs.

II. Current Policy and Proposed Clarification

A. Background

Section 1886(d)(1)(A) of the Act provides for a three-year transition period during which a declining portion of a hospital's total prospective payment amount (that is, the "hospital-specific portion") is based on a hospital's historical Medicare costs in a given base year, and a gradually increasing portion of the payment (that is, the "Federal portion") is based on a regional rate per discharge in the first year and a blend of regional and national rates per discharge in the second and third years. Beginning with the fourth year, and continuing thereafter (that is, for hospital cost reporting periods beginning on or after October 1, 1986). Medicare payments for inpatient hospital services will be determined under a national DRG payment methodology.

The hospital-specific portion of the prospective payment rate paid during the transition period is calculated in accordance with section 1886(d)(1)(A)(i)(I) of the Act for cost reporting periods beginning in Federal fiscal year 1984, and in accordance with section 1886(d)(1)(A)(ii)(I) of the Act for cost reporting periods beginning in Federal fiscal years 1985 and 1986. Under these provisions, the hospital-specific portion of the rate is a specified percentage of the hospital's "target amount" for the cost reporting period, as defined in section 1886(b)(3)(A) of the Act.

The "target amount" is a concept introduced into the Act for purposes of the reimbursement system that preceded the prospective payment system. The Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97-248) established limits on the permissible rate of increase of Medicare reimbursement for hospital operating costs during cost reporting periods beginning in fiscal year (FY) 1983 through FY 1985. These limits were defined in terms of a target amount, which, under section 1886 (b)(3) of the Act, was in turn defined for each hospital as the allowable operating costs per case incurred by the hospital during the cost reporting period immediately preceding the first cost reporting period subject to the rate-of-increase ceiling (that is, generally, cost reporting periods beginning between October 1, 1981 and September 30, 1982), adjusted by a specified annual update factor. Thus, for example, the target amount for a hospital whose cost reporting period began October 1, 1982, was determined by reference to the hospital's operating costs per case during the year beginning October 1, 1981 (its "base year"). Under section 1886(b)(3) of the Act, the target amount for each succeeding year is determined by applying the specified increase factor to the previous year's target amount. For a further explanation, see our regulations at 42 CFR 405.463, which explain the ceiling on the rate of hospital cost increases.

For most hospitals, the rate-of-increase limitations were in effect for only one year when they were superseded by the prospective payment system. However, in accordance with §§ 405.463(a)(2) and 412.22(b) (formerly § 405.-471(b)), the rate-of-increase limits continue to apply to those hospitals that are excluded from the prospective payment system. Because the prospective payment system bases the hospital-specific portion on a percentage of the hospital's "target amount" (determined using its base year costs), each hospital's costs during its base year continue to be relevant under the prospective payment system.

B. Current Policy

Although section 1886(d)(1)(A) of the Act bases the hospital-specific portion of the prospective payment rate on the target amount without any reference to adjustments or modifications of that amount, our implementing regulations at § 412.71(b) (formerly § 405.474(b)) provide for a number of modifications to base year costs that affect the amount of the hospital specific portion of the prospective payment rate. These regulations were issued in accordance with section 1886(d)(5)(C)(iii) of the Act, which authorizes the Secretary to provide by regulation for such exceptions and adjustments to the prospective payment rates as the Secretary deems appropriate.

In determining what changes are appropriately made to base year costs (and hence to the hospital-specific portion of the prospective payment rate), we must be consistent with the statute's reliance on a particular base year as the foundation for determining the amount of the hospital-specific portion of the rate. The hospital-specific portion of the rate was not intended to reflect a hospital's actual current per-case costs, but rather its per-case costs during the designated base year, increased by an annual update factor. The legislative history for Pub. L. 98-21 explains in the House Committee on Ways and Means report that, "the payment amount, like the target amount under present law, is projected from the hospital's cost base. Because the payment can be determined without reference to the hospital's costs in the current year, it can be prospectively determined." (See H.R. Rep. No. 98-25 Part 1, 98th Cong., 1st Sess., 136 (1983).) Similarly, the conference committee report for Pub. L. 98-21 noted that the hospital-specific portion is related to each hospital's own experience in a base cost reporting year. (See H.R. Rep. No. 98-47, 98th Cong., 1st Sess., 181 (1983).)

The statute's use of base year per-case costs rather than more current information is not surprising in light of the limited purpose of the hospital-specific portion of the rate. For hospitals other than sole community providers, the hospital-specific portion of the prospective payment rate exists for transitional purposes only, and is completely eliminated after a hospital has been subject to the prospective payment system for three years. Many hospitals have per-case costs that differ significantly from the Federal rates that will apply when the transition is complete and that form an increasingly large portion of a hospital's payments during the transition period. In light of the potentially poor correlation between a hospital's current costs and the important national (and regional) rates, it is not plausible that Congress intended for the hospital-specific portion of the rate to be finely adjusted to reflect the hospital's current situation. Rather, the hospital-specific portion of the rate was designed simply to cushion, to some degree, the transition to a prospective payment system based on Federal rates. The Senate report on Pub. L. 98-21 states that "the phase-in of national DRG rates over the three-year period is designed to minimize disruption that might otherwise occur because of sudden changes in reimbursement levels." (See S. Rep. No. 98-23, 98th Cong., 1st Sess. 53 (1983).)

Thus, the regulations governing modifications to base year costs authorize only those adjustments that do not undermine the statute's reliance on a particular year of hospital operations as the basis for the amount of the hospital-specific portion of the payment rate. Modifications are limited to those necessary to make the hospital's base year experience comparable to costs that will be paid under the prospective payment system. In other words, the modifications currently authorized in § 412.-71(b) of our regulations are made for the purpose of more accurately estimating the costs that would be incurred in the future by a hospital that carried on the same operations that it did in the base year. This ap-

proach is consistent with the conference committee managers' statement expressed in the Conference Committee Report on Pub. L. 98-21 that "the managers recognize that, in some cases, the Secretary will have to use estimates to adjust some portions of the hospital's base year experience to make it comparable to inpatient operating costs that will be paid under the prospective system—e.g., FICA taxes that would have been paid if the hospital had been in the Social Security system or the adjustment needed to exclude the nursing differential which is no longer payable." (See H.R.Rep. No. 98-47, noted above, at 181-182.)

C. Proposed Clarification of Current Policy

Since the hospital-specific portion relates to the target amount under the rate-of-increase ceiling, some hospitals have questioned whether changes to inpatient operating costs permitted under §§ 405.460 and 405.463 of our regulations will affect the hospital-specific portion of the rate under the prospective payment system. Because the regulations do not address this question specifically, this proposal would clarify our position on this issue.

Our current policy is to revise the hospital-specific portion of the prospective payment rate to take into account exceptions, exemptions and adjustments granted under §§ 405.460 and 405.463 to the extent that they apply to base year costs. Exceptions, exemptions, or adjustments granted for periods subsequent to the base year do not change the hospital-specific portion of the prospective payment rate since neither base year costs nor the target amount itself is altered by such action.

Under current operating procedures, it is the onset of the event that caused the distortion that dictates which period's costs are adjusted. Thus, if a cost distorting event occurs in the base year, operating costs in the base year (for purposes of application of the rate-of-increase ceiling) are adjusted.

Since the target amount is defined as base year operating costs increased by a target percentage, an adjustment due to an event that occurs in the base year would result in an increase in the target amount. Likewise, since section 1886(d)(1)(A) of the Act, which defines the hospital specific portion of the prospective payment rate, references the target amount, the hospital-specific portion of the rate would also be revised. Because at least a portion of the cost for the service that gives rise to the adjustment occurred in the base year, we believe this policy is consistent with the legislative history of Pub. L. 98-21, which states that "during the phase-in period, some portion of the prospective payment rate will be related to each hospital's own experience in a base cost reporting year." (See H.R. Rep. No. 98-47, 98th Cong., 1st Sess., 181 (1983).) This is also consistent with the position, previously discussed in this preamble, that modifications of base year costs be limited not those necessary to make the hospital's base year experience comparable to the inpatient operating costs that will be incurred under the prospective payment system by a hospital that carried on the same operations that it did in the base year.

In granting an exception or adjustment for a cost distorting event that occurs in a period subsequent to the base year, operating costs of that period would be adjusted downward for purposes of comparison to the target amount. In this situation, however, the target amount is not altered, and therefore would not give rise to a change in the hospital-specific portion of the rate. Thus, we believe that neither the statutory language, which references the target amount, nor the committee reports, which reference the hospital's experience in the base year, contemplates that costs arising from a change in operations subsequent to the base year would be recognized in the prospective payment rates.

Moreover, we believe any policy of allowing rate-of-increase adjustments for post-base year experience to

affect the hospital-specific portion of the prospective payment rate would create difficult problems. If changes were limited to those resulting in increased hospital reimbursement, there would be an unwarranted upward bias in Medicare expenditures. If, however, HCFA pursued a policy of reducing rate-of-increase target amounts to account for lowered hospital costs, the result might unfairly penalize hospitals throughout the prospective payment transition period for cost-reduction efficiencies introduced in anticipation of the prospective payment system.

Accordingly, for all these reasons, we are proposing to amend § 412.72(a)(3) (formerly § 405.474(b)(3)) of the regulations to make clear that any exemptions, exceptions, or adjustments granted under §§ 405.460 and 405.463 of the regulations for the base year would result in a change in the hospital-specific portion of the prospective payment rate.

In view of the prospective nature of the payment system and the conference committee's expectation that determinations would be made on the basis of the best information available at a time prior to a hospital's entering the system (See H.R. Rep. No. 98-47 Part 1, 98th Cong., 1st Sess., 182 (1983)), we believe that changes to base year costs arising from the granting of an exception, exemption, or adjustment to base year costs should affect the hospital-specific portion of the rate only on a prospective basis. Since the hospital-specific portion of the rate was to be determined by an intermediary in accordance with the regulations, based on its assessment of the best information available for a base period, we do not believe that a subsequent change to the base period costs that occurs as the result of HCFA granting an exception, or adjustment under §§ 405.460 and 405.463 would impugn the validity of the intermediary's efforts to make a good faith assessment of the data available to it. Therefore, a retroactive revision would be inappropriate. How-

ever, we believe a prospective revision for subsequent years would be appropriate. Therefore, the proposed regulation specifies that changes to the hospital-specific portion of the rate that result from exemptions, exceptions or adjustments granted under §§ 405.460 and 405.463 would be made on a prospective basis effective with the first day of the hospital's first cost reporting period beginning on or after the date of a favorable determination by HCFA on the hospital's exemption, exception or adjustment requests.

We have also considered whether additional regulations should be issued under section 1886(d)(5)(C)(iii) of the Act, the general authority for the prospective payment system exceptions and adjustments, to recognize changes (other than those already permitted in § 412.72 (formerly § 405.474) in a hospital's cost per case after the base period. For the same reasons stated above in connection with statute's and legislative history's dependence upon base year costs, we do not believe that, in general, it would be appropriate to adjust base year costs to reflect changes in a hospital's operations subsequent to the base year.

We have, however, considered it appropriate to recognize certain changes in operations for sole community hospitals. We intend to propose to these adjustments in a separate proposed notice.

III. Regulatory Impact Statement

A. Executive Order 12291

Executive Order 12291 requires us to perform and publish a regulatory impact analysis for any major rule. A major rule is any regulation that is likely to result in an annual effect on the economy of $100 million or more; a major increase in costs or prices for consumers, individual industries, Federal, State or local government agencies, or geographic regions; or a significant adverse effect on com-

petition, employment, investment, productivity, innovation, or on the ability of U.S.-based enterprises to compete with foreign-based ones.

We have determined that this proposed rule does not meet any of the criteria for a major rule. This proposal would clarify our current policy and practice, not change it, and would not affect the level of payments that hospitals receive under existing regulations. Therefore, it would not have an effect that would meet any of the major rule criteria of E.O. 12291. For these reasons, a regulatory impact analysis is not required.

B. Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA), 5 U.S.C. 601 through 612, requires us to perform and publish an initial regulatory flexibility analysis for any proposed rule unless the Secretary certifies, in accordance with 5 U.S.C. 605(b), that the rule would not, if promulgated, have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we treat all hospitals as small entities. However, as discussed above with reference to E.O. 12291, this proposed rule would merely clarify our current policy, not change it. We do not expect this proposal to significantly affect hospitals, since they will continue to be paid at the same level as they are paid under existing regulations. Therefore, we have determined, and the Secretary certifies, that this proposed rule would not have a significant economic impact on a substantial number of small entities.

C. Paperwork Reduction Act

This proposed change would not impose information collection requirements; consequently, it need not be reviewed by the Executive Office of Management and Budget under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 et seq.).

IV. Other Required Information

A. Public Comment

Because of the large number of pieces of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments that we receive by the date specified in the "Dates" section of this preamble, and, if we decide to proceed with a final rule, we will respond to the comments in the preample of that rule.

List of Subjects in 42 CFR Part 412

Health Facilities, Medicare.

42 CFR Part 412 would be amended as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES

1. The authority citation for Part 412 continues to read as follows:

Authority: Secs. 1102, 1871, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395ww).

2. In § 412.72, the introductory language of paragraph (a) is reprinted unchanged for the convenience of the reader; a new paragraph (a)(3)(ii) is added; and current paragraph (a)(3)(ii) is revised and redesignated as paragraph (a)(3)(iii) to read as follows:

§ 412.72 Modification of base-year costs.

(a) *Bases for modification of base-year costs.* Base-year costs as determined under § 412.71(d) may be modified under the following circumstances:

* * * *

(3) *Recognition of additional costs.*

(ii) The intermediary may adjust base year costs to take into account any exception, exemption, or adjustment

to base year costs granted under §§ 405.460 or 405.463 of this chapter. Exceptions, exemptions or adjustments to a hospital's operating costs for a period subsequent to the base year that arise from an event that occurs after the base year may not be used for the purposes of changing the base year costs used in determining the hospital-specific rate.

(iii) The intermediary will recalculate the hospital's base-year costs, incorporating the additional costs recognized as allowable for the hospital's base-year. Adjustments to base-year costs to take into account these additional costs and any exceptions, exemptions, or adjustments permitted under paragraph (a)(3)(ii) of this section—

(A) Will be effective with the first day of the hospital's first cost reporting period beginning on or after the date of the revision, order, finding, review decision, or granting of the exception, exemption or adjustment.

(B) Will not be used to recalculate the hospital-specific portion as determined for fiscal years beginning before the date of the revision, order, finding, review decision, or granting of the exception, exemption, or adjustment.

* * * *

(Catalog of Federal Domestic Assistance Programs No. 13.773, Medicare-Hospital Insurance Program)

Dated: March 15, 1985.

Carolyne K. Davis,
Administrator, Health Care Financing Administration.

Approved: May 24, 1985.

Margaret M. Heckler,
Secretary.

[FR Doc. 86-5067 Filed 3-7-86; 8:45 am]

BILLING CODE 4120-01-M

APPENDIX Q

DEPARTMENT OF HEALTH & HUMAN SERVICES

Mr. Leonard C. Homer
Ober, Kaler, Grimes and Shriver
1600 Maryland National Bank Building
10 Light Street
Baltimore, Maryland 21202

Dear Mr. Homer:

This is in response to your letter in which you requested a revision to Greenville Hospital Center's (GHC) base period costs for determining the hospital-specific rate under the prospective payment system (PPS) to rectify a computational error by South Carolina Blue Cross pursuant to regulations at 42 CFR 405.474(b)(1)(iv)(A). The request is based on the transfer of an intern and resident (J&R) training program from Greenville General Hospital (GGH) to GHC after the effective year whereby the indirect costs associated with the transfer are not recognized in GHC's hospital-specific rate.

We do not agree that failure to change GHC's base period costs, to include the effect of the transfer of the medical education program from GGH to GHC, constitutes a mathematical error in computation under regulation 405.474(b)(1)(iv)(A). The cost per discharge calculation by the intermediary was based on the best evidence available at the time the hospital became subject to PPS and thus no computational error can properly be asserted.

We have, however, decided to treat your request as an application for an adjustment to GHC's cost per case for the cost reporting period subject to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), as authorized by regulation 405.463(h). Under that regulation, HCFA may adjust operating costs considered in establishing a hospital's TEFRA-year cost per case to take

into account factors which could result in a significant distortion in the operating costs of inpatient hospital services. Because of the substantial magnitude of the costs affected by the Greenville realignment, we have determined that a significant distortion in GHC's operating costs would exist without an adjustment, and we are therefore, granting the adjustment described below.

As you know, the amount of the hospital-specific portion (HSP) of PPS payments is determined by reference to each hospital's target amount under TEFRA. The adjustment to GHC's TEFRA-year costs granted by this letter will therefore result in increased HSP payments to GHC, effective for cost reporting periods beginning after the date of this letter. No retroactive increase in HSP amounts is available because of the requirement that intermediaries determine base period costs at the beginning of a cost reporting period based on the best evidence then available. At the time that GHC became subject to PPS, it had not applied for, and HCFA had not granted, any adjustment to TEFRA-year operating costs. Accordingly, the intermediary's computation of GHC's base period costs was based on the best evidence of GHC's operating costs then available, and the revision to GHC's target amount resulting from the determination in this letter can affect only future cost reporting periods under PPS.

Using the information submitted, your request for base period adjustment is based on the following:

1. Prior to October 1, 1983, there was a realignment within the Greenville Hospital System (GHS) in which beds and services previously associated with GGH were transferred to GHC. The realignment is as follows:

	GHC	GGH
Beds in Base Period	358	411
Beds as of 10/01/83	712	30

2. In conjunction with the above realignment, the medical education program also shifted to GHC. I&R shifted as follows:

	GHC	GGH
I&R in Base Period	13	85
I&R as of 10/01/83	98	0

3. The number of I&Rs utilized in computing the additional payment for indirect medical education under PPS at GHC is 98. However, the indirect cost of 85 of those I&Rs is included in GGH's base period cost report.

4. The effect of the change in the number of I&Rs is that the Federal portion of the prospective payment for GHC will recognize the additional I&Rs while the hospital-specific portion (HSP) of the prospective payment will not be comparable.

While we concur with these facts and the effect on the hospital-specific rate portion of the prospective payment, we believe that the correct amount of the adjustment and the methodology for computing it would differ from the methodology that you propose for the following reasons:

1. Indirect medical education costs is not an identifiable cost for facilities. Only direct medical education is identifiable as a result of cost allocation. Since all I&Rs will be in GHC under PPS, all the direct cost will be considered a passthrough cost for reimbursement purposes. However, the effect of indirect medical education is different because the actual cost experience of the two facilities is different (i.e. an intern in the base year at GHC does not have the dollar for dollar impact on indirect medical education costs that the same intern would have at GGH).

2. If a lack of comparability accrues to GHC's base period from the addition of the I&Rs then there is a reciprocal effect in GGH. Since the addition of these

I&Rs produce more indirect costs in the 712 bed GHC hospital, then removal of these same interns would necessarily reduce indirect costs in the GGH 30 bed hospital. Nevertheless, your solution proposes that the hospital-specific rate for GGH remain unchanged while the HSP for the 712 bed hospital be increased to include the indirect cost effect of 98 I&Rs.

3. The I&R factor cannot be used in the manner suggested since it only measures increases in the ratio. Furthermore, since we must adjust the hospital-specific rate for both GHC and GGH, we must use the unadjusted base year cost per discharge, updated to 1984 (for GHC ($2,392.33) and GGH ($3,467.69)) as contained in GHS's October 12, 1983 letter to us.

4. Since the basis for adjusting GGHs and GHC's base period costs comes from regulations implementing TEFRA we must look to these regulations, rather than the PPS regulations, to determine the effect that indirect medical education has on hospital costs for the base period and the reporting year (see enclosure). This effect is .0606 for each .1 increase above zero for the ratio of I&R to beds. Applying this to GHC's I&R ratio of .03631 would result in an increase of $51.51 in the base period cost per discharge to take into account the indirect cost of 13 interns and residents. Thus, if there were no I&Rs, GHC's base period cost per discharge would be $2,340.82. Utilizing this same reasoning, GGH's updated base period cost per discharge would be $3,081.48 if there were no I&Rs. Conversely, including 98 I&Rs in GHC during the base period results in increasing GHC's base period cost per discharge to $2,536.07.

In conclusion, we agree that GHC's base period costs should be increased. However, GGH's base period costs should be decreased. These revisions would not be retroactively effective. They would be effective as of the first day of each hospital's next cost reporting period.

Sincerely yours,

/s/ Carolyne K. Davis
CAROLYNE K. DAVIS, Ph.D.

Enclosure

ENCLOSURE

	GHC	GGH
1. Ratio of I&R beds	$\frac{13}{358} = .036312$	$\frac{85}{411} = .0206812$
2. Effect of Indirect Medical Education on Base Period Costs	$\frac{.036312 \times .0606}{.1} = .022005$	$\frac{.026812 \times .0606}{.1} = .125328$
3. Elimination of Inputed effect of Indirect Medical Education on Base Period Costs Per Discharge	$\frac{\$2392.33}{(1+.022005)} = \$2340.82$	$\frac{\$3467.68}{(1+.125328)} = \$3081.48$
4. Pro Forma I&R Ratio	$\frac{98}{712} = .137640$	
5. Pro Forma Effect of Indirect Medical Education on Base Period Costs Resulting from increase in bed size and transfer of medical education program .0606 x	$\frac{.137640}{.1} = .083409$	$\frac{0}{30} = 0$
6. Pro Forma Base Period Cost Per Discharge Updated to 1984 ((L3x(5+1))	$\$2340.82 \times 1.083409 = \$2536.07$	$3081.48

APPENDIX R

DEPARTMENT OF HEALTH &
HUMAN SERVICES

Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

April 24, 1986

Ms. Amanda W. Crosby, CPA
Manager
Provider Audit and Reimbursement
Medicare Services
Arkansas Blue Cross and Blue Shield, Inc.
P.O. Box 1418
Little Rock, Arkansas 72203-1418

Dear Ms. Crosby:

This is in reference to your letter concerning Newport Hospital (NH), Provider Number 04-0054. NH has requested an adjustment to its base year under the regulations at 42 CFR 405.463(h) and has requested "new provider" status under the prospective payment regulations. Both of these requests are based on the distortion in costs which resulted from the move to a new facility on November 22, 1982. Their base year is the cost reporting period July 1, 1982 through June 30, 1983.

The provider built a new facility after the old one failed to meet the 1967 Life Safety Code requirements and closure was threatened. The old facility was a wooden structure with approximately 30,000 square feet of floor space. Some administrative offices, the communications system, the laboratory, and the pharmacy were housed in an adjacent building. For FYE 6/30/82 there were a total of 86 beds (78 acute care and 8 coronary care) and the

occupancy level was approximately 47% with 2852 discharges.

They moved to the new facility on November 22, 1982. The new building has about 80,000 square feet. They expanded Radiology and added Nuclear Medicine and also expanded the Surgery Department and added Urology. The Cardiology Department was updated and new diagnostic equipment was added. For the first seven months in the new building (November 22, 1982-June 30, 1983), the occupancy was 83% with 2,533 discharges. By FYE 6/30/84 (the first full year in the new building), their occupancy level was 72% with 3,907 discharges. The hospital has indicated that the FYE 6/30/84 is more representative of their "normal" occupancy. The peak in occupancy was a result of people waiting when possible until the new facility opened.

During the expansion, the staff increased from 133 full-time equivalents (FTE's) to 223. This increased the number of FTEs per occupied bed from 3.3 to 3.8 The medical staff has increased from 20 to 31 members and the number of specialties has increased by 3. All of this expansion resulted in an increase in the cost per discharge that was not ameliorated by the increase in occupancy. With more than double the floor space, it would be expected that maintenance and housekeeping would increase significantly and would be reflected in all service areas. It is also not unexpected to find an increase in administrative and general cost where services, space and personnel have all increased. In those areas (routine and special care) where services have remained similar between the old facility and the new, the cost increases were moderate considering the changes in housekeeping, maintenance, etc. In the ancillary departments where the changes were most extensive, the increase in the cost per discharge was substantial. However, the resulting cost per discharge in the new facility is well under the per group cost limit and does not appear unreasonable. The increase in staff is

commensurate with the increase in services and occupancy. The difficulty lies with the significant increase in the cost per discharge between the two years.

A comparison of the cost per discharge between the base year and the year subject to the rate-of-increase limit shows an increase of 15.6%. This is greater than twice the target rate of 6.9 percent. However, since this included 5 months of costs from the period in which they operated out of the old facility and was therefore not truly representative of the costs of operation in the new facility, we compared the costs between the 7 months of the base year in the new facility and the full year ending 6/30/84. This did not give the results that would have been expected if the difference in the cost per discharge were due entirely to the move to the new building. Based on the modified short period cost report for the period from 11/22/82 through 6/30/83, the cost per discharge for the first 7 months in the new facility was $1,430.25. This is less than the cost per discharge for the full base year when the period in the old building is considered. When the first 7 months in the new facility are compared to the first full year in the new building, there is an 16.5% increase in the operating cost per case.

We also looked at changes in total costs of the facility. To do this, we used the direct costs from Worksheet A of the HCFA-2552. We took the costs for the short period and annualized them by dividing by 7 (to obtain the cost per month) and multiplying by 12 to estimate the costs on a yearly basis. A comparison of the annualized total costs for FYE 1983 and the total costs for FYE 1984 shows an increase of 4%. However, this 4% increase occurred during a period of declining occupancy when it would normally be expected that certain variable costs should be declining commensurate with the reduced patient load. If these same costs (Worksheet A costs) are compared on a per discharge basis, they show the same 16% increase as reflected in the Medicare cost per dis-

charge. These cost increases appear to be primarily in the ancillary departments, particularly Radiology (185.4%), Laboratory (27.4%), and Electrocardiology (48.3%). The increases in the Employee Health and Welfare (283.4%), Nursing Administration (230.9%) and Dietary (48.5%) cost centers also appear to be excessive.

In looking at total costs, we also compared total costs after stepdown from Worksheet 3, Column 21 on a per discharge basis. These costs showed the same pattern with the addition of a 65% increase from one period to the next in the costs of Drugs Charged to Patients.

We also explored the possibility of creating a base using the first 12 months in the new building (i.e., an estimate of costs for the period 11/22/82-11/30/83). We used 7 months from the period 11/22/82 through 6/30/83 plus an estimate of costs for 5 months in FYE 1984. (Costs from HCFA-2552, Worksheet D-1, Part II, line 56, were divided by 12 to obtain the average monthly costs and that amount was multiplied by 5 to obtain the estimated costs for 5 months). The discharges were handled in the same way (i.e.,—actual discharges for the first 7 months in the new facility plus 5/12 of the discharges in the FYE 1984). The result was a cost per discharge of $1,539.45 and a target amount of $1,645.67 (1,539.45 x 1.069). The resulting cost increase between this adjusted base year and FYE 1984 is 9%, which is still greater than the target rate of increase for the period.

Since NH had indicated that the first 7 months occupancy rate was not typical, we looked at the impact the change in occupancy had on cost per discharge. One way of doing this is to assume that the costs remain constant as occupancy changes. This is not entirely accurate over a period of time, but does give some indication of the impact of shifting occupancy rates. To do this, we assumed that FYE 1984 occupancy rates were normal. To convert the occupancy rate for the last 7 months of FYE 1983 to an estimated "normal" rate, we divided the Medi-

care discharges (999) by .83 (the actual FYE 1983 occupancy rate) and multiplied that by .7267 (the assumed normal rate from FYE 1984). This resulted in an adjusted discharge count of 875. When this adjusted number of discharges is divided into the 1983 Medicare costs for the 7 month period, the cost per discharge is $1,643.22. This is very similar to the cost per discharge for FYE 1984 of $1,677.49, which reflects an increase of only 2%. Of course, this is distorted somewhat by the methodology. However, it does indicate that NH's problem is the result of the distortion in the occupancy rate. Therefore, we are granting NH an exception for the period ending 6/30/83.

Since the the changes that resulted in the distortion occured in the base year, NH's target amount should be increased to $1,756.60 ($1,643.22 times 1.069). This amount is based on the estimate of the costs from the modified short period cost report for the 7-month period ending 6/30/83. These costs should be audited and, if there is a change, the target rate should be adjusted appropriately.

Sincerely yours

/s/ Linda M. Magno
LINDA M. MAGNO
Director
Division of Hospital Payment Policy
Bureau of Eligibility,
Reimbursement and Coverage

APPENDIX S

DEPARTMENT OF HEALTH &
HUMAN SERVICES

Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

May 14, 1986

Ms. Amanda W. Crosby, CPA
Manager
Provider Audit and Reimbursement
Medicare Services
Arkansas Blue Cross and Blue Shield, Inc.
P.O. Box 1418
Little Rock, Arkansas 72203-1418

Dear Ms. Crosby:

This is in further reference to the exception request for Newport Hospital (NH), Provider Number 04-0054 per a telephone conversation between Joe Kemper of your staff and Ann Pash of my staff. NH has been granted an adjustment under the rate of increase ceiling for the cost reporting period July 1, 1982 through June 30, 1983. Since this is also their base year for determining the hospital specific portion (HSP) of their payment rate under the prospective payment system (PPS), the question has been raised as to the changes in the HSP and the effective date of the changes. Also, NH's request for an exemption as a new provider was questioned.

Since the exception was granted for the year ending June 30, 1983 (their base year), an adjustment can be made to their HSP. However, under the regulations at 42 CFR 412.72 (formerly 42 CFR 405.474) this adjustment may only be made prospectively. The HSP should be adjusted for the cost reporting period beginning July 1, 1986, the

first cost reporting period beginning on or after the date of the decision.

As to the request for new provider status under PPS, under the regulations at 42 CFR 412.72 (formerly 42 CFR 405.474(d)) a hospital may be considered a new hospital for the purpose of determining PPS rates if it is either a hospital newly participating in the Medicare program or a hospital under new ownership that meets certain other requirements as to change in occupancy and management. Since NH is neither a newly participating hospital nor a hospital under new management, it does not qualify as a new hospital for the purpose of determining PPS rates.

Sincerely yours

/s/ Linda M. Magno
LINDA M. MAGNO
Director
Division of Hospital Payment Policy
Bureau of Eligibility,
Reimbursement and Coverage